

Thank you for your referral. Please fill out the following information so that we may service the patient. We will contact the patient and schedule time for the services you prescribe.

Patient Name:		DOB	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Phone:	Alternate Phone:	Email:	
Best Method of Contact:			

TMH Employee: Yes No
Preferred Location: Medical Center Willowbrook Methodist Sugar Land Methodist

Primary Diagnosis (required)	ICD 9	Secondary Diagnosis	ICD 9

Diet Order: _____ (If not completed, to be determined by RD based on diagnosis)
Labs: Please attach recent pertinent labs, history, and physical, or complete the following:

	Date		Date		Date
Glucose		CHOL		Potassium	
HbA1c		HDL/LDL		BUN/Cr	
Microalbuminuria		TG		Phos	

Diabetes Education: New Diagnosis ____ Yes ____ No
Please check all that apply

- | | |
|---|---|
| <input type="checkbox"/> Type 1 | <input type="checkbox"/> Diet/Exercise Controlled _____ |
| <input type="checkbox"/> Type 2 | <input type="checkbox"/> Oral (s) Name: _____ |
| <input type="checkbox"/> GDM-EDD: _____ | Dose: _____ Time/Day: _____ |
| <input type="checkbox"/> Insulin Initiation | <input type="checkbox"/> Insulin: _____ |
| <input type="checkbox"/> Additional Orders: _____ | Units: _____ Time/Day: _____ |
| | <input type="checkbox"/> Other: _____ Time/Day: _____ |

Patient will be screened by educator and placed in appropriate class or individual sessions.

Patients taught diabetes management skills: SMBG, medications, nutrition, exercise, long term complication as outlined by ADA guidelines.

*****Please attach recent pertinent labs and medical history information*****

Physician's Name	Phone # / Fax #	Scheduling	713-441-5975
Physician's Signature	Date/Time	Fax	713-790-6366

