HAYSMED
THE UNIVERSITY OF KANSAS HEALTH SYSTEM

Diabetes Solutions

Request for Consultation or Referral

Physician Request For: ❑ Consult ❑ Referral

Patient Information

Name ________________________________

Address ______________________________

City/State/Zip _________________________

Date of Birth __________________________

Phone # ______________________________

Cell # ________________________________

Insurance Carrier and # ________________

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Reason for Referral

- ❑ New diagnosis
- ❑ Uncontrolled diabetes
- ❑ Gestational diabetes
- ❑ Lifestyle modifications
- ❑ Hypoglycemia or hyperglycemia
- ❑ Change in treatment regimen
- ❑ High risk for complications
- ❑ Insulin pump start
- ❑ Other____________________________

Lab Results (Please fill in the blank or fax copy to 785.623.5108)

HgbA1c______________	Date ______________
BMI________________	Date ______________
Microalbumin_________	Date ______________
Creatinine___________	Date ______________
LDL________________	Date ______________
HDL________________	Date ______________
Triglycerides_________	Date ______________

Physician Order (mark all that apply)

- ❑ Self–Management Diabetes Program (Two 5 hour group sessions)
- ❑ PA–C to calculate and adjust meds
- ❑ One–on–one diabetes education
- ❑ Gestational diabetes care
- ❑ Provide instructions or comments

Diabetes Medications and Doses
(please send med list)

Diagnosis

- ❑ Type 1 Diabetes
- ❑ Type 2 Diabetes
- ❑ Gestational Diabetes
- ❑ Pre–existing diabetes and pregnancy
- ❑ Pre–diabetes or impaired fasting glucose
- ❑ Metabolic Syndrome

Complications

- ❑ Hypoglycemia unawareness
- ❑ Retinopathy
- ❑ Neuropathy
- ❑ Cardiovascular disease
- ❑ Nephropathy
- ❑ Gastroparesis
- ❑ Other____________________________

Barriers that Impede Learning Ability

- ❑ Non–adherence
- ❑ Visual/hearing impairment
- ❑ Learning disability
- ❑ Impaired mental status
- ❑ Impaired dexterity
- ❑ Language barrier______________________

Clinic________________________________

Provider's Name________________________

Date_________________________________

Address______________________________

City/State/Zip__________________________

Phone #______________________________

Fax #________________________________

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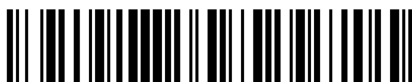
Physician Signature: Date/Time:

Please fax referral/consult to 785.623.5108. If questions, please call 855.429.7633 or 855–HAYSMED. Thank you for the referral.

Patient Label



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