

**WAKEMED CHILDREN'S DIABETES AND ENDOCRINOLOGY CENTER
PHYSICIAN REFERRAL**

Patient Name _____ Parent Name _____ Insurance _____ Insur ID# _____ DOB _____	Daytime phone _____ Evening Phone _____ Address _____ _____ Height _____ Weight _____
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ENDOCRINE CONSULT (please include growth chart and medical records)
 Reason: _____

DIABETES CONSULT Date of Diagnosis _____ <input type="checkbox"/> 250.03 Type 1 uncontrolled <input type="checkbox"/> 250.01 Type 1 controlled <input type="checkbox"/> 250.00 Type 2 controlled <input type="checkbox"/> 250.02 Type 2 uncontrolled *for Pre-diabetes, use Energize Screen and referral *for Insulin pump, use Insulin Pump Program referral	Medical Status: <input type="checkbox"/> Newly Diagnosed <input type="checkbox"/> New to Insulin <input type="checkbox"/> New to Oral Meds <input type="checkbox"/> Severe hypoglycemia or hyperglycemia <input type="checkbox"/> Uncontrolled diabetes (see A1c) <input type="checkbox"/> Other _____
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Current Diabetes Regimen: Oral Meds: _____ Insulin: _____ _____ Other Meds: _____	Sliding Scale _____ Is patient carb counting? Yes No Carb Ratio 1 unit per _____ grams of carb
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EDUCATION CONSULT

Diabetes Basics (covers all content required for ADA Recognized Programs):
*Diabetes Basics – indiv session with CDE for assessment, diabetes overviews & treatment, medication, exercise, blood glucose monitoring, sick day management, acute and chronic complications
 *Food for Thought – session with registered dietitian for meal plan/carb counting
 *Taking Charge – group class teaching advanced diabetes concepts including pattern management

Advanced Carbohydrate Counting/Pattern Management (Intensive Management)

Case Management Consult – follow-up and phone contact with Case Manager for children with identified management issues

Recent Lab Results (please fax recent lab results):
 A1c _____% Date _____ Blood Pressure _____ Date _____
 Cholesterol _____ LDL _____ HDL _____ Triglycerides _____ Date _____
 Other Relevant Lab Results _____

Physician Signature _____ Phone _____
 Physician Name _____ Practice _____ Fax _____

Please fax completed form to 919-231-0314
 WakeMed Children's Diabetes and Endocrinology Center
 (919) 350-7584