PALOS HEALTH

DIABETES AND METABOLISM CENTER REFERRAL

15300 West Avenue
Suite 122
Orland Park, IL 60462
708-226-2626

Patient Information

Name: _____ Date of Birth: ____/____/____

Address: _____

City/State/ZIP:_____Phone:_____

Insurance:_____

ID number: _____Group #_____

~if available, fax copy of insurance card along with the referral for reference ~

□**Referral to Nurse Practitioner:** Comprehensive history and physical, evaluation of diagnostic data, initiation of treatment specific to patient needs to improve DM control and/or metabolism condition

□**Referral to Diabetes Education and/or Medical Nutrition Therapy**

_____Initial Diabetes Self-Management Education (10 hours the first year if Medicare)

_____Follow-up Diabetes Self-Management Education (2 hours annually if Medicare)

_____Initial Medical Nutrition Therapy (3 hours the first year if Medicare)

_____Follow-up Medical Nutrition therapy (2 hours annually if Medicare)

Other Requests_____

Specific Goals for Patient: _____

_____

Diagnosis

□Type 1 DM
□Type 2 DM
□Gestational Diabetes
□Pre-diabetes
□Obesity
□Dyslipidemia
□Polycystic Ovarian Syndrome
□Other_____

Reason for Referral

□New Onset □ Inadequate glycemic control □Change in treatment plan
□Other: _____

Referring Provider Name:_____**NPI:**_____

Signature:_____**Office Phone & Fax #:**_____

PLEASE FAX COMPLETED FORM TO (708) 403-8492