

University of Kansas Medical Center: Cray Diabetes Center

Room 1-116 KU Hospital

3901 Rainbow Blvd, MS 1042, Kansas City, KS 66160

Ph 913-588-3960 Fax 913-588-4023

www.kumc/edu/cray

Referral for Diabetes Clinic &/or Education Visit

Patient Name: _____ **DOB:** _____ **SSN:** _____

Address: _____ **Phone(s):** _____
_____ Insurance _____ KU MR# _____

Referring Provider: _____ **Clinic** _____
Address: _____ **Phone:** _____ **Fax:** _____
_____ **Contact person:** _____

Diagnosis: Type 1 Type 2 on diet/exercise/orals Type 2 on insulin/other injectable
Barriers to self-management skills: please circle

Emotional, impaired mobility, visual/hearing impairment, learning disability, impaired mental status, socioeconomic challenges, language spoken _____

Comments: _____

*Please send recent clinic notes, medication list, and laboratory results

Visit Type(s) please check boxes below

1. Urgent: _____ Routine (first available)
(appointment with any available provider)

2. Diabetes medical management (ongoing care)
Initial visit with: Endocrinologist PA-C or ARNP

3. One-time evaluation by MD and back to referring provider's care for diabetes.

4. **EDUCATION:**

Group Comprehensive Management Skills (service not covered by Medicaid)

Individual Education Sessions: (select topics)

Comprehensive Diabetes Self-management Skills (Medicaid or learning barriers)

Nutrition Management

Blood Glucose Monitoring

Pre-pump training

Continuous Glucose Monitoring: professional

Injectable start: **MUST** send medication orders with referral. Patient **must** come with medications.

Referring Provider Signature _____ **Date** _____

The patient will be contacted with appointment information by phone and mail as quickly as possible after receipt of your return fax. Complete information from you will facilitate the appointment process.