PRESBYTERIAN COLLEGE
SCHOOL of PHARMACY

Wellness Center
307 North Broad Street, Clinton, SC 29325
864-938-3930 | pcspwellness@presby.edu

REFERRAL FOR DIABETES CARE & EDUCATION

Patient's Full Name: _____ **DOB:** _____

Address: _____ **Phone#:** _____

Diabetes Diagnosis:

☐ Type 1, controlled ☐ Type 1, uncontrolled ☐ Type 2, controlled ☐ Type 2, uncontrolled
☐ Gestational ☐ Pre-Existing DM with Pregnancy ☐ Pre-diabetes

Referral For:

☐ Initial Comprehensive Assessment and Diabetes Self-Management Education and Support
☐ Refresher Diabetes Self-Management Education and Support *(recommended annually)*
☐ Continuous Glucose Monitoring (CGM) Support

Indicate any barriers to group learning or additional training requiring 1:1 education:

☐ Impaired mobility ☐ Impaired vision ☐ Impaired hearing ☐ Impaired dexterity
☐ Impaired mental status/cognition ☐ Language barrier: _____
☐ Eating disorder ☐ Learning disability or other (please specify): _____

Comments:

_____

_____

_____

Referring Provider's Name: _____

Referring Provider's Signature: _____ **Date:** ____/____/_____

After completing the referral form, fax to (866) 291-0649

Thanks in advance for sharing a copy of the patient's most recent labs!