



Lifespan Cardiovascular Institute

Rhode Island Hospital • The Miriam Hospital
Newport Hospital

Delivering health with care.®

The Center for Cardiac Fitness at The Miriam Hospital

208 Collyer Street, 2nd Floor, Providence, RI 02904

Phone: 401-793-5810 • Fax: 401-793-5815

Diabetes Outpatient Education Referral

Referral Available in LifeChart for Lifespan Physicians Under Procedure 94200045

PATIENT _____ DOB ____/____/____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

DIABETES SELF-MANAGEMENT EDUCATION/TRAINING (DSME/T): ☐ Initial group DSME ☐ Follow-up DSME/T

Check type of training services and number of hours requested

Patients with special needs requiring individual (1 on 1) DSME/T

Check all special needs that apply

- ☐ Group not available
- ☐ Vision impairment
- ☐ Hearing impairment
- ☐ Language limitations
- ☐ Other

DIAGNOSIS

Please check the applicable diagnosis below:

Type 1

__ E10.9

__ E10.65

Type 2

__ E11.9

__ E11.42 (neuralgia/polyneuropathy)

__ E11.65

Pre-diabetes

__ R73.09

Please send recent labs for eligibility & outcomes

Your patient will receive:

- nine hours of professional instruction taught by a nurse, dietitian and pharmacist, who are certified diabetes educators
- education for the self-management skills required to achieve blood glucose control and to make the behavior changes necessary to live a healthy lifestyle

Topics include:

Monitoring Your Blood Glucose; Interpreting and Using the Results
Prevention, Detection and Treatment of Chronic Complications
Incorporating Nutritional Management into Your Lifestyle
Incorporating Physical Activity into Your Lifestyle
Prevention, Detection and Treatment of Acute Complications
Diabetes Disease Process and Treatment Process
Using Your Medications Safely
Strategies to Address Psychosocial Issues
Pregnancy and Diabetes/ Gestational Diabetes
Strategies to Promote Health/ Change Behavior

Staff will provide you with the patient's progress and outcomes at the conclusion of the program.

NAME OF PHYSICIAN (PLEASE PRINT) _____ PHONE _____ FAX _____

DATE _____ TIME _____ NPI _____ MD SIGNATURE _____