Date:_____

Transition Clinic Referral Form

PHYSICIAN ORDER FORM
United Regional Healthcare
Phone: (940) 764-8725 Fax: (940) 764-8179

Patient Name: _____ Date of Birth:_____

Address: _____

Home Phone: _____ Work:_____ Cell:_____

Social Security Number: _____ Physician: _____

*Insurance Company: _____ Policy or Group #_____
(or Patient Face sheet)

*Insurance Phone Number (not needed for Medicare or Medicaid): _____

****REFERRAL WILL EXPIRE IN ONE YEAR***

Diagnosis: **Diabetes**

____ E10.9 Type 1 Diabetes
____ E10.65 Type 1 Diabetes (uncontrolled)
____ E11.9 Type 2 Diabetes
____ E11.65 Type 2 Diabetes (uncontrolled)
Smoking Cessation
____ F17.200 Nicotine Dependence

****Uncontrolled Diabetes is defined as AIC 7% or greater, and/or recurrent Hypo/hyperglycemia requiring ER or hospitalization****

Instruct patient as follows:

- ☐ Please bring all medications to the first appointment

FOR DIABETIC PATIENTS ONLY

- ☐ Please bring glucometer and testing supplies

LAB: Date: _____ HbA1c _____ FBG _____ Chol. _____ Trig. _____ HDL_____

DL_____ ALT._____ Urine Micro albumin _____ Creat. _____ Bun_____

PHYSICIAN SIGNATURE:_____ Phone #_____

I authorize United Regional Transition Clinic to obtain lab test results to assist in my health care:

_____ _____

Patient or legal guardian signature Date