# APPALACHIAN REGIONAL HEALTHCARE SYSTEM
# MOVING FORWARD WITH DIABETES PROGRAM REFERRAL

Paul H. Broyhill Wellness Center
232 Boone Heights Drive | Boone, NC 28607

PATIENT NAME: _____ DOB: _____/_____/_____

PATIENT PHONE # (_____) _____-_____ SEX: ☐ M ☐F

REFERRAL DATE: _____ REFERRING PHYSICIAN PHONE: _____

REFERRING PHYSICIAN FAX: _____

**DIAGNOSIS w/ ICD-10 CODE**

☐ Type 1 Diabetes without complications-E10.9
☐ Type 1 Diabetes with hyperglycemia-E10.65
☐ Type 2 Diabetes without complications-E11.9
☐ Type 2 Diabetes with hyperglycemia-E11.65
☐ Gestational Diabetes, diet controlled-O24.410
☐ Gestational Diabetes, insulin controlled-O24.414
☐ Gestational Diabetes, controlled by oral hypoglycemic drugs-O24.415
☐ Gestational Diabetes, unspecified control- O24.419
☐ Glucose Intolerance-R73.02

**CHECK ANY OF THE FOLLOWING FOR PATIENTS WITH DIABETES**

☐ Newly diagnosed
☐ Recurrent hyperglycemia
☐ Recurrent hypoglycemia
☐ Change in diabetes treatment regimen
☐ During transitions in care

**PLEASE CHECK IF ANY APPLY TO YOUR PATIENTS WITH DIABETES**

☐ Retinopathy
☐ Neuropathy
☐ Hypertension
☐ Nephropathy
☐ Dermatopathy
☐ Gastroparesis
☐ Cardiovascular Disease
☐ Hyperlipidemia
☐ Impaired Dexterity
☐ Impaired vision/hearing/speech
☐ Impaired mental status
☐ Learning disability
☐ Language barrier
☐ Other

_____
_____


Effective Date: 06/21/2018
Revised Date: 06/27/2018
Form #: 11417

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|---|---|
| **Paul H. Broyhill**<br>**Wellness Center** | Patient Name_____<br>Date of Birth_____<br>Phone Number_____<br>Please Fill in or Affix a Patient Label |

**INSULIN REGIMEN**

Type/Dose _____

**PLEASE COMPLETE THE FOLLOWING AND ATTACH MOST RECENT LABS**

A1C _____ FBG _____ Total Cholesterol _____ HDL _____ LDL _____

Triglycerides _____ Weight _____ Height _____ Blood Pressure _____

**Upon completion of the Thriving with Diabetes program, the above patient may become a member of the Paul H. Broyhill Wellness Center for independent exercise or the THRIVE program for medically supervised exercise. Please indicate any exercise limitations of specific guidelines below:**

_____

**REFERRING PHYSICIAN** Please print name _____

**SIGNATURE OF PHYSICIAN _____ DATE: _____ Time: _____**

1. **To schedule appointments call The Wellness Center at (828) 266-1060**
2. **Then fax this form *and* most recent office note to (828)- 386-2049**


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