Virginia Mason Memorial
Community Health

Provider Referral:

***Please attach most recent chart notes and labs**

## Community Health Programs

Patient First Name: _____ Last Name: _____

Date Of Birth: _____ A1c Value: _____ A1c Test Date: _____

Telephone: _____ E-MAIL: _____

All classes offered in English and Spanish. LANGUAGE PREFERENCE: English _____ Spanish _____

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☐ **Diabetes Prevention Program–$50** (available in Spanish)

Appropriate for patients who have prediabetes as diagnosed by ONE of the following lab tests:

_____ Fasting Plasma Glucose (FPG) test _____ Oral Glucose Tolerance (OGTT) test _____Glycated Hemoglobin (HbA1c) test

**OR**

Appropriate for high risk patients who have at least two of the following criteria:

_____Overweight (BMI 24 or higher)

_____Has a parent or sibling with diabetes

_____Inactive- does not exercise more than two times a week

_____ Had gestational diabetes

_____ Gave birth to a baby weighing more than 9 lbs.

_____ 45 years of age or older

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## Diabetes Education and Management Classes (available in Spanish)

Choose appropriate class for patients who have been diagnosed with Diabetes

_____ **Diabetes Wellness Classes** DX Code: _____ Authorization# _____
*4 Sessions*

_____ **Individual Diabetes Appointment** DX Code: _____ Authorization# _____
*For patients with special needs Check all needs that apply:* ☐ *Hearing* ☐ *Vision* ☐ *Cognitive Issue* ☐ *Language* ☐ *Behavior Disorder* ☐ *Physical*
☐ *Additional Training* _____

_____ **Insulin Initiation and adjustment** DX Code: _____ Authorization# _____

_____ **Gestational Diabetes management** DX Code: _____ Authorization# _____

_____ **Medical nutrition therapy consult** DX Code: _____ Authorization# _____
*Up to 3 hours with registered dietitian*

_____ **Nail Care** DX Code: _____ Authorization# _____

_____ **Continuous Glucose Monitor** DX Code: _____ Authorization# _____
*Initiating and management*

_____ **Insulin Pump Management** DX Code: _____ Authorization# _____

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**Additional notes or information:** _____

## Referring Provider Information

**Health Care Provider Name** (Please print): _____

Provider Signature (Required): _____

Clinic Name: _____ Date: _____

Phone: _____ Fax: _____

**For questions, call Community Wellness at 509-249-5243 / Fax completed form to 509-577-5006**

Entered: _____