



## Texas Children's Health Plan, Inc.

### DIABETES DISEASE MANAGEMENT REFERRAL FORM

Phone: (832) 828-1430 Fax: (832) 825-8745

Date \_\_\_\_\_

Your Name: \_\_\_\_\_

Office Number: \_\_\_\_\_

Member ID: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Member Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_

Sex: M or F (circle one)

Primary Language: \_\_\_\_\_

Diabetes Diagnosis Code(s): \_\_\_\_\_

Other Diagnoses: \_\_\_\_\_

Parent or Guardian \_\_\_\_\_

Member/Parent Contact Info: Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Referring Provider: Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

#### DIABETES INFORMATION:

Has a written Sick Day Management Plan: \_\_\_ Yes \_\_\_ No

ER visits for Diabetes - # in last year \_\_\_\_\_ Hospital Admissions for Diabetes - # in last year \_\_\_\_\_

Diabetes medications Member is using: \_\_\_\_\_

#### REQUESTS:

\_\_\_ Member needs education by phone or mail on:

- Understanding of diabetes
- How to follow sick day management plan
- Assistance with obtaining medication and/or supplies, dme
- Self-management education by Certified Diabetes Educator
- Other education \_\_\_\_\_

\_\_\_ Home visit for member at risk of serious complications or \* high risk member (attach clinical note for need of home visit)

\* for example: 1 hospital admission or 2 or more ER visits in last 12 months for DKA or severe hypoglycemia,

\_\_\_\_\_  
Provider's Signature