Virginia Mason Memorial

Community Wellness

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 _____

☐ **Diabetes Prevention Program** (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

☐ **Diabetes Education and Management Classes** (available in Spanish)

Choose appropriate class for patients who have been diagnosed with Diabetes

_____ **Diabetes Wellness,** DX Code: _____ Authorization# _____
4-month program delivered in multiple sessions

_____ **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# _____

☐ **Chronic Disease Self-Management Program—My Health My Life** (available in Spanish)

Patients will learn simple techniques on how to live healthy by managing their symptoms. *Support person or caregiver encouraged to attend

Appropriate for adult patients with the following:

_____ COPD _____ Diabetes _____ CHF _____ Chronic pain _____ Other _____

_____ Physically and emotionally able to participate in a weekly 2.5-hour class for 6 weeks.

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: _____