Physician Referral

Utah DIABETES CENTER

Payson RX Express
869 S. Turf Farm Rd, UT 84651
Phone: (801) 609-2300
udc@paysonrxexpress.com

Fax: (801) 609-2305

CONFIDENTIAL

Patient Information

First Name: ____________________ **Last Name:** ____________________

Sex: ○ Male ○ Female **DOB:** ___ / ___ / ___

Street Address: ____________________

City: ____________________ **State:** ________ **Zip Code:** ____________

Home Phone: ____________________ **Cell:** ____________________

Insurance: ○ Medicare ○ Medicaid ○ Self Pay ○ Other ____________________

Insurance Phone Number: (   ) ___ - _________

Insurance Name: ____________________ **ID #:** ____________________

Diagnosis Type:

○ Type 1: Uncontrolled (E10.65)
○ Type 2: Uncontrolled (E11.65)
○ Gestational (O24.419)
○ Pre-diabetes (R73.09)
○ Other: ____________________

*** Please Select the Following ***

○ **Diabetes Education: Compensation Instruction**

- 4 Hour Group Class: *Education & Training*
- Individual Appointment: *Care Plan & Review*
- Medical Nutrition Therapy (MNT) Services

*Established Care Plan and goals will be given to both the patient and the prescriber.

○ **Glucometer with BG Test Strips**

Sig: Test ______ times daily.

Refills: ____________________

○ **Diabetic Shoe Consult and Services**

(Diagnosis of diabetes, neuropathy with an initial foot exam required)

○ **Start patient on the following medications:**

Rx:	**Rx:**
Sig:	**Sig:**
Refills:	**Refills:**

Physician Information

____
Physicians Printed Name:

____
Physicians Signature:

Phone #: (   ) ___ - _________

Fax #: (   ) ___ - _________

Date: ____________________

***

Please FAX updated Med List, Vaccine List and most recent Lab Work with this completed Referral Form to

801-609-2305

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