DESERT SPRINGS HOSPITAL
MEDICAL CENTER
A Member of The Valley Health System
Diabetes Treatment Center

Inquiry Date: _____
Appointment Date:_____
Call Taken By: _____

Patient's Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Birth Place _____Primary Language Spoken _____

Religion: _____ Race: _____ Marital Status: _____

Patients S.S.#: _____ Patient's Employer: _____

Employer's Address: _____ Work #: _____

Occupation: _____Email Address: _____

1st Insurance Name: _____ Member's Name: _____

Member's DOB: _____ Member's S.S.#: _____ Rlt to Pt.: _____

Member's Employer: _____ Member's Occupation: _____

Employer's Address: _____Work #: _____

Insurance Customer Service Phone #: _____

2nd Insurance Name: _____ Member's Name: _____

Member's DOB: _____ Member's S.S.#: _____ Rlt to Pt.: _____

Member's Employer: _____Member's Occupation: _____

Employer's Address:_____Work #:_____

Insurance Customer Service Phone #: _____

Have You Ever Received Services at DSH Before? _____

Have You Ever Received Diabetes Education Before: _____ When: _____ Where: _____

Primary Care Physician: _____Phone #: _____

Referring Physician: _____Phone #: _____

Emergency Contact_____

Relationship: _____Phone Number: _____

Who Called____MD____PT____Office

WhoHasReferral____PT____FAX____NEED

Services: **( ) Individual ( ) 4hr Basic Mgt/Core ( ) Comp. Program ( ) Medical Nutrition Therapy**

( ) Meter Teach ( ) Follow-Up ( ) Dietitian ( ) Gestational ( ) CGMS ( ) Insulin Instruction

Age: _____Sex: ____ Height: _____ Weight: _____ Lost/Gained/Stable ( ) Single birth ( ) Twins

Gestational Prior Weight: _____Weeks: _____
Gestational: Work ( ) Yes ( ) No If yes Shift:_____ Usual meal times: Breakfast_____ Lunch_____

Dinner:_____Bedtime_____

IBW:_____ BMI:_____ BEE:_____ Recommended Kcal:_____

Special Comments: _____

_____

Appointment Date/s: _____ Time/s: _____

( ) Monday ( ) Tuesday ( ) Wednesday ( ) Thursday ( ) Friday ( ) Saturday