



PHYSICIAN'S ORDER FOR OUTPATIENT EDUCATION SERVICES

I am referring _____ for medically necessary outpatient diabetes self-management education.

SSN: _____ **DOB:** _____ **Physician:** _____

Daytime Phone: _____ **Evening Phone:** _____

Address: _____

Language: _____ **Special Needs:** _____

Note to Physician: The following areas - written diagnosis, medical conditions, complications and plan of care - are required for diabetes self-management training reimbursement by various regulatory agencies, payers, and or insurance companies.

INSURANCE INFORMATION		DIAGNOSIS	
COMPANY	AUTHORIZATION #	ICD-9 CODES: _____	
Aetna		Type 1 _____	Gestational _____
BCBC		Type 2 _____	Other _____
Cigna		MEDICAL CONDITIONS:	COMPLICATIONS:
Doctors Health Plan		Newly diagnosed _____	Vascular _____
Healthsource		New to insulin _____	Neuropathy _____
Medicaid		New to oral agents _____	Nephropathy _____
Medicare		Severe hyper/hypoglycemia _____	Retinopathy _____
Prudential		A1c 8.5 _____	Other _____
Wellpath		Other _____	
Other			

RECENT LAB RESULTS (May attach copy of lab results)	NUTRITIONAL COUNSELING
HbA1c _____ BP _____ Triglycerides _____	Obese _____ Weight Gain _____
Cholesterol _____ LDL _____ HDL _____ Date _____	ADA Diet _____ Other _____

PLAN OF CARE	DIAGNOSIS/SCHEDULERS
Weight Management _____ Current Wgt. _____ Wgt. Goal _____	Lamaze _____ Breastfeeding _____
Self blood glucose monitoring _____ Frequency _____	Sibling class _____ Gestational _____
Carbohydrate Counting _____ Diet Only _____ Follow-up _____	Nutritional type _____
Insulin pump training _____ How to give SubQ injections _____	Coumadin/Lovenox _____

INSULIN START
Type _____ Dosage _____ Time _____
Type _____ Dosage _____ Time _____
Patient to discontinue oral medication? Yes _____ No _____
Oral Agents: _____ Dosage _____ Time _____

Insulin Injections _____
Infant CPR _____
BCLS/ CPR _____
Follow-up _____
Insulin pump _____ Sensor _____
Diabetes Group _____
Diabetes one-on-one _____
Ostomy _____
Pump training _____
CHF _____
Other _____

GESTATIONAL DIABETES
Diet Only _____ Insulin Type _____ Dosage _____
Results of GTT _____ Pre-pregnancy Wgt. _____
Desired blood sugar range:
Fasting _____ 1hr.pp _____ 2hr. Pp _____
Lamaze _____

OSTOMY EDUCATION
Colostomy _____
Ileostomy _____ Urostomy _____

PHYSICIAN SIGNATURE _____ **DATE** _____

To schedule an educational session, call Community Wide Scheduling 938-7749 and fax this completed form to 989-6584