



Johnston Memorial
HOSPITAL

Growing With The Community

Community Wide Scheduling
509 N. Bright Leaf Blvd. Smithfield, NC 27577
919/938-7752
FAX 919/989-6584

Physician's Order For Outpatient Educational Services

I am referring _____ for medically necessary outpatient self-management education. SSN _____ DOB ____/____/____ Physician _____
Daytime Phone # _____ Evening Phone # _____
Address _____
Language _____ Special Needs _____
Exercise Activity: unrestricted moderate to light walking not appropriate for this patient

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.....Thanks!.....Patsy Stewart BSN, CDE Nurse Educator

Insurance Information:

Healthsource Authorization # _____
 Cigna Authorization # _____
 Doctors Health Plan Authorization # _____
 Prudential Authorization # _____
 Aetna Authorization # _____
 Medicaid # _____
 BCBS _____
 Medicare # _____
 Wellpath _____
 Other _____

Diagnosis:

ICD-9 Codes: _____
Type 1 _____ Gestational _____
Type 2 _____ Other _____

Medical Conditions:

Newly diagnosed _____
New to insulin _____
New to oral agents _____
Severe hyper/hypoglycemia _____
A1c > 8.5 _____
Other _____

Complications

Vascular _____
Neuropathy _____
Nephropathy _____
Retinopathy _____
Other _____

Recent Lab Results: HbA1c _____ BP _____ Triglycerides _____
May attach copy of lab results Cholesterol _____ LDL _____ HDL _____ Date _____

Nutritional Counseling

Obese _____ Weight Gain _____ ADA Diet _____ other _____

Plan of Care:

Weight Management _____ Weight now _____ Weight goal _____
Self blood glucose monitoring _____ Frequency _____
Carbohydrate Counting _____ Diet Only _____ Follow-up _____
Insulin pump training _____ How to give SubQ injections _____

Insulin Start:

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

Gestational Diabetes: Diet only _____ Insulin type _____ Dosage _____
Results of GTT _____ Pre-pregnancy Weight _____
Desired blood sugar range: fasting _____ 1hr. pp _____ 2hr. pp _____
Lamaze _____

Diagnosis / Schedulers

Lamaze _____ Breastfeeding _____
Sibling class _____ Gestational _____
Nutritional type _____
Coumadin/Lovenox _____
Insulin Injections _____
Infant CPR _____
BCLS/ CPR _____
Follow-up _____
Insulin pump _____
Diabetes Group _____
Diabetes one-on-one _____
Ostomy _____
Pump training _____
CHF _____
Other _____

Ostomy Education

Colostomy _____
Ileostomy _____ Urostomy _____

Physician Signature _____ Date _____

Please fax completed form to (919) 989-6584 Johnston Memorial Community Wide Scheduling