Date:_____

DIABETES SELF MANAGEMENT EDUCATION AND MEDICAL NUTRITION THERAPY
PHYSICIAN ORDER FORM

United Regional Healthcare Diabetes Education Department
Phone: (940) 764-8190 Fax: (940) 764-8179

Patient Name:_____ Date of Birth:_____

Address:_____

Home Phone:_____ Work:_____ Cell:_____

Social Security Number:_____ Physician:_____

*Insurance Company:_____ Policy or Group #_____
(or Patient Facesheet)

*Insurance Phone Number (not needed for Medicare or Medicaid): _____

EDUCATION SERVICE REQUESTED ***REFERRAL WILL EXPIRE IN ONE YEAR***

Diagnosis: **Diabetes** **Medical Nutrition Therapy**

____ E10.9 Type 1 Diabetes _____ R73.01 IGT (Prediabetes)
____ E10.65 Type 1 Diabetes (uncontrolled)
____ E11.9 Type 2 Diabetes
____ E11.65 Type 2 Diabetes (uncontrolled)
____ Pre-existing Diabetes with Pregnancy *please circle one*: 024.319; 024.019; 024.119
____ 099.810 Gestational Diabetes EDC_____

Uncontrolled Diabetes is defined as AIC 7% or greater, and/or recurrent Hypo/hyperglycemia requiring ER or hospitalization*

Instruct patient as follows:

- ☐ Comprehensive diabetes outpatient self-management training services, group instruction and follow up.
- ☐ Diabetes outpatient self-management training services, individual instruction. (Circle any that apply.) Note: Medicare patients require documentation of the need for individual instruction from the referring physician. "Immediate need to begin insulin therapy, Impediments to learn ability, Visual/Hearing Impairment, Impaired mental status, Language Barrier, and/or other special needs: _____.
- ☐ Dietitian regarding:_____
- ☐ Education and management of _____insulin pump per URHCS protocol.
- ☐ CGMS study due to _____.
(for widely fluctuating blood sugars, uncontrolled DM, nocturnal hypoglycemia, etc.)

LAB: Date:_____ HbA1c _____ FBG _____ Chol. _____ Trig. _____ HDL_____

DL_____ ALT._____ Urine Microalbumin _____ Creat. _____ Bun_____

PHYSICIAN SIGNATURE:_____ Phone #_____

I authorize United Regional Patient Education Department to obtain lab test results to assist in my health care:

_____ _____
Patient or legal guardian signature Date