ST. MARY'S HEALTH CARE SYSTEM
A Member of Trinity Health

OUTPATIENT ORDER FORM
DIABETES EDUCATION

Appt. Date: _____

Appt. Time: _____

Arrival Time: _____

2470 Daniells Bridge Road, Bldg. 300
Athens, Georgia

TO SCHEDULE: Fax this order, clinical records, and demographics to: 224-607-3242
FOR QUESTIONS: Call 706-389-2060

PATIENT'S LEGAL NAME	DATE OF BIRTH	PATIENT PHONE	INSURANCE COMPANY NAME

PHYSICIAN OFFICES Tests cannot be performed without listing the signs/symptoms and/or reason(s) for each test ordered along with the ICD-10 Code. code. Federal law requires that inform you when ordering tests that will be paid under federal health programs, including Medicare and Medicaid, physicians should only order tests that are medically necessary for diagnosis or treatment of the patient, not for screening purposes.

Your office will be contacted prior to test being performed if form is not complete.

PATIENT SIGNS/SYMPTOMS	ICD-10 CODE:

PHYSICIAN NAME (please print)	❑ CALL REPORT TO_____
	❑ FAX REPORT TO_____
X_____ _____	SPECIAL INSTRUCTIONS
ORDERING PHYSICIAN'S SIGNATURE DATE/TIME ***Signature Stamps Are Not Valid***	

APPOINTMENTS NECESSARY FOR EXAMS LISTED BELOW

PLAN OF CARE:

- ☐ **DIABETES SELF-MANAGEMENT TRAINING(DSMT)**
  TOTAL 10 HRS: INDIVIDUAL ASSESSMENT (1 HR.)
  GROUP INSTRUCTION (9 HRS.)
- ☐ **YEARLY DSMT FOLLOW-UP** (2HRS)
- ☐ **MEDICAL NUTRITION THERAPY** TOTAL 3 HRS (NUTRITION ASSESSMENT, COUNSELING, AND FOLLOW-UP)
- ☐ **YEARLY MNT FOLLOW-UP** (2 HRS.)
- ☐ **DSMT** INCLUDING INSULIN ADMINISTRATION
  TYPE & DOSAGE _____
- ☐ **INSULIN PUMP TRAINING**
- ☐ **GESTATIONAL INSTRUCTION**
  INSULIN ORDER _____
- ☐ **PRE-DIABETES EDUCATION**
- ☐ **SPECIAL NEEDS** _____

LAB RESULTS:

FASTING BLOOD SUGAR _____ DATE _____
HbA1c _____ DATE _____
MICROALBUMIN _____ DATE _____
CHOLESTEROL _____ DATE _____
TRIGLYCERIDES _____ DATE _____
HDL _____ DATE _____
LDL _____ DATE _____

SELF BLOOD GLUCOSE MONITORING:

☐ DAILY ☐ 2X / DAY ☐ 3X / DAY ☐ 4X /DAY ☐ OTHER

REASON FOR REFERRAL:

PT HAS EXPERIENCED ONE OR MORE WITHIN THE LAST TWELVE MONTHS:

- ☐ **NEW ONSET DM-** DATE OF INITIAL DX _____
- ☐ **HGB A1C ≥8.5% ON TWO CONSECUTIVE TESTS, AT LEAST 3 MONTHS APART**
- ☐ **A CHANGE IN TX REGIMEN:**
  ☐ FROM NO DM MEDS TO MEDICATIONS
  ☐ FROM ORAL MEDS TO INSULIN
- ☐ ACUTE EPISODES OF SEVERE HYPOGLYCEMIA OR HYPERGLYCEMIA IN THE PAST YEAR REQUIRING EC VISITS OR HOSPITALIZATION
- ☐ HIGH RISK COMPLICATIONS:
  ☐ FOOT NEUROPATHY, ULCERS, DEFORMITIES, OR AMPUTATION
  ☐ PRE- PROLIFERATIVE OR PROLIFERATIVE RETINOPATHY OR PRIOR EYE LASER TX
  ☐ NEPHROPATHY RELATED TO DM WHEN MANIFESTED BY ALBUMINURIA OR ELEVATED CREATININE