Diabetes Institute at UPMC Hamot
104 East 2nd Street
Erie, PA, 16507

Phone: 814-877-2123
FAX: 814-877-8565

PHYSICIAN ORDER FORM for Diabetes Self-Management Education/Medical Nutrition Therapy Outpatient Services

PLEASE PRINT CLEARLY

I am referring: _____

for medically necessary outpatient diabetes self-management education.

Phone#: _____ Other#: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

This information is required:

Health Insurance: _____

Insurance ID#: _____

Subscriber:
Date of Birth: _____

Patient:
Date of Birth: _____

NOTE TO PHYSICIAN: The following areas: 1. Diagnosis, 2. Medical Status, 3. Complications and 4. Plan of Care are required for diabetes outpatient reimbursement. Please pay special attention to these actions.

1. **DIAGNOSIS:** Must be listed below, because all insurance companies will only pay for these diagnoses.

- ☐ Diabetes, type 2 controlled;
- ☐ Diabetes, type 1 controlled;
- ☐ Diabetes, type 2 uncontrolled;
- ☐ Diabetes, type 1 uncontrolled;
- ☐ Gestational Diabetes;
- ☐ Diabetes, with pregnancy;
- ☐ MNT Diagnosis _____

2. MEDICAL STATUS:

- ☐ Newly Diagnosed
- ☐ New to Insulin
- ☐ New to oral anti-diabetes agents
- ☐ Severe hypoglycemia occurring during past year requiring ED visit or hospitalization
- ☐ Uncontrolled diabetes as evidenced by A1C ≥ 8.5 for 2 consecutive times 3 or more months apart
- ☐ Special Concerns _____

3. COMPLICATIONS:

- ☐ Retinopathy
- ☐ Neuropathy
- ☐ Nephropathy(i.e. albuminuria)
- ☐ Any vascular disease
- ☐ Frequent hypoglycemia
- ☐ Foot (i.e. ulcer, charcot)
- ☐ Obesity or increased BMI
- ☐ Other _____

4. PLAN OF CARE FOR DIABETES EDUCATION: - Please check desired components

☐ **COMPREHENSIVE DIABETES PROGRAM:** 4 group sessions for a total of ten hours to include meter training, assessment, behavior change and goal setting, diabetes overview/treatment, chronic/acute complications, nutrition basics, exercise, foot care, etc.

☐ Patient is unable to benefit from group classes due to impairment of speech, language, hearing, sight or cognitive ability.

MODULES

- ☐ Basic meal planning
- ☐ Carbohydrate counting
- ☐ Refresher Class
- ☐ Medical nutrition therapy
  --Dietitian to determine calorie level
- ☐ Gestational diabetes

☐ **Insulin/medication start (1.5 hr)**
List: Type, dosage, and time
_____
_____

Continue oral diabetes medications?
- ☐ YES
- ☐ NO

SPECIAL PROGRAMS:

☐ **Insulin pump instructions (6.5 hrs)**
Specify model name:
_____

☐ **CGM**

☐ Special Concerns _____

5. GLUCOSE RANGE: Pre-meal: _____ 1 hr pp ≤ _____ 2 hr pp ≤ _____ Bedtime: _____

6. RECENT TEST RESULTS - Please send results with order form: A1C _____ /Date: _____

Cholesterol _____ **LDL** _____ **Triglyceride** _____ **HDL** _____ **/Date:** _____ **FBS Random** _____ **/Date** _____

CDE will adjust the patient's insulin dosage based on the patient's individual needs.

Physician Signature _____ **Practice Name** _____

Physician Name (Please Print) _____

Date _____ **Phone** _____ **Fax** _____

Please Fax Completed form to 814-877-8565

This order form will expire after 3 months from the date signed.