

**Physician Order For Diabetes Outpatient Training Services**

1. I am referring: \_\_\_\_\_ for medically necessary outpatient self-management training.  
 DOB: \_\_\_\_\_ Phone numbers: Home - \_\_\_\_\_ Cell - \_\_\_\_\_  
 Physician name: \_\_\_\_\_ Physician's Phone Number: \_\_\_\_\_

**2. Insurance Information:**

<input type="checkbox"/> HealthSource Authorization # _____	<input type="checkbox"/> Aetna Authorization # _____	<input type="checkbox"/> Medicare
<input type="checkbox"/> Cigna Authorization # _____	<input type="checkbox"/> Doctors Health Plan Authorization # _____	<input type="checkbox"/> Wellpath
<input type="checkbox"/> Prudential Authorization # _____	<input type="checkbox"/> BCBS	<input type="checkbox"/> State Health Plan
	<input type="checkbox"/> Other _____	

**Note to Physicians:** The following information is required for outpatient diabetes training reimbursement by various regulatory agencies, payors and insurance companies: **Written Diagnosis, Medical Conditions, Complications and Plan of Care.**

<b>3. Diagnosis:</b> _____ _____ <input type="checkbox"/> Type 1 <input type="checkbox"/> Gestational <input type="checkbox"/> Type 2 Non-Insulin Treated <input type="checkbox"/> Type 2 Insulin Treated <input type="checkbox"/> Diabetes Mellitus Difficult to Classify	<b>Medical Conditions</b> <input type="checkbox"/> Newly Diagnosed <input type="checkbox"/> New to insulin <input type="checkbox"/> New to oral agents <input type="checkbox"/> Severe hypoglycemia or hyperglycemia this past year requiring hospitalization or ER visit	<b>Complications</b> <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Neuropathy <input type="checkbox"/> Frequent hypoglycemia <input type="checkbox"/> Nephropathy <input type="checkbox"/> Retinopathy <input type="checkbox"/> HbA1c $\geq$ 8.5, 2 consecutive times, 3 or more mos. apart
	Most recent HbA1c result: _____ Date _____ (Please attach pertinent lab results.) Weight: _____ lbs. Blood Pressure: _____ Date _____ Cholesterol: _____ LDL _____ HDL _____ Date: _____	

**4. Plan of Care \*\*\*PLEASE SELECT THE PROGRAM YOUR PATIENT SHOULD ATTEND\*\*\***

- DIABETES SELF MANAGEMENT PROGRAM** - This program includes diabetes overview; diabetes management skills, including acute and long term complications, individual meal plans, exercise, sick day rules, blood glucose monitoring, and medications. Follow up sessions are at 6 and 12 months.
- DIET/NUTRITION MANAGEMENT ONLY**
- CARB COUNTING - INSULIN TO CARB RATIO**  
 \_\_\_\_\_ Introduction  
 \_\_\_\_\_ Dosage  
 \_\_\_\_\_ Review  
 \_\_\_\_\_ Insulin-to-carb ratio
- INSULIN PUMP TRAINING**  
 \_\_\_\_\_ New to Pump (Needs pump class/Saline Start)  
 \_\_\_\_\_ Review Pump use  
 \_\_\_\_\_ Pump Upgrade  
 \_\_\_\_\_ Advanced Pump Skills
- OTHER** \_\_\_\_\_
- GESTATIONAL DIABETES**  
 \_\_\_\_\_ Diet Only    \_\_\_\_\_ Diet and Glucose Monitoring
- INJECTABLE MEDICATION ADMINISTRATION**  
 \_\_\_\_\_ Insulin: \_\_\_\_\_ Type \_\_\_\_\_  
 Insulin-to-carb ratio:  Yes Ratio: \_\_\_\_\_  No  
 \_\_\_\_\_ Symlin: \_\_\_\_\_ Dosage I:C Ratio \_\_\_\_\_  
 \_\_\_\_\_ Byetta: \_\_\_\_\_ Dosage  
 \_\_\_\_\_ Diabetes Medications dose adjustment: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ Nutrition Counseling (for patients on above medications)

**INDIVIDUAL CONSULTS** are available specifically for patients unable to attend group classes due to special needs or barriers.

Special Needs/Barriers to Learning: \_\_\_\_\_

Additional Information: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_