

**PHYSICIAN ORDER FORM
DIABETES SELF-MANAGEMENT PROGRAM**

Great Outcomes

Last:	A1c	WT	BP
--------------	------------	-----------	-----------

Name:	DOB	Sex: M_____ F_____
Patient Address:		
City:	State:	Zip:
Home Phone: ()	Work Phone: ()	

☞ **Please fax patient's insurance information & current lab results to (817) 514-5246, Attn: Karen DeLozier.** ☞

REFERRED FOR:

- _____ **Diabetes Self-Management Program** (Includes Medical Nutrition Therapy (MNT), diabetes assessment, 8 hours of group classes and 1 group follow-up.)
- _____ **Gestational Diabetes Self-Management Program** (Includes nutrition, glucose monitoring, ketone testing, diabetes management during pregnancy, exercise recommendations/precautions).
- _____ **Insulin instruction**

DIAGNOSIS:

- _____ 250.00 DM, unspecified type, not stated as uncontrolled
- Type 1**
- _____ 250.01 DM, Type 1, without mention of complication, not stated as uncontrolled
- _____ 250.03 DM, Type 1, uncontrolled
- _____ 250.91 DM, Type 1, not stated as uncontrolled, w/ unspecified complication
- _____ 250.93 DM, Type 1, uncontrolled w/ unspecified complication
- Type 2**
- _____ 250.02 DM, Type 2, uncontrolled
- _____ 250.90 DM, Type 2, not stated as uncontrolled, w/ unspecified complication
- _____ 250.92 DM, Type 2, uncontrolled w/ unspecified complication
- _____ 790.29 Pre-Diabetes
- _____ 648.80 Gestational Diabetes

REASON FOR REFERRAL:

- _____ Newly Diagnosed
- _____ Previously diagnosed with education > 5 yrs ago
- _____ Previously diagnosed with no prior education
- _____ Change in medical condition, diagnosis and/or regimen

DIABETES MEDICATIONS:

	Presently Taking		Recently Added/New	
	Type	Dosage	Type	Dosage
Oral				
Insulin				

INSULIN DELIVERY:

_____ CDE's discretion _____ Insulin Pen _____ Syringe _____ Innolet _____ Other: _____

Physician's Signature (required): _____ Date: _____
 Physician's Printed Name: _____ Phone #: _____
 Contact Person: _____ Fax #: _____
 NPI#: _____ (required) UPIN# _____