I am referring ____ **for medically necessary outpatient self-management training.**

Insurance/Health Plan ____

Insur. ID # ______________________ Group #________________________

Date of Birth ____________________ S.S. # __________________________

Daytime Phone #___________________

Evening Phone #___________________

Home Address ____________________

____

Height __________ Weight __________

DIAGNOSIS ICD-9 CODE:

☐ 250.00 Diabetes type 2 controlled
☐ 250.01 Diabetes type 1 controlled
☐ 250.02 Diabetes type 2 uncontrolled
☐ 250.03 Diabetes type 1 uncontrolled
☐ 648.00 Diabetes with pregnancy
☐ 648.83 Gestational diabetes
☐ 790.20 Abnormal GT (pre-diabetes)
☐ 277.7 Dysmetabolic syndrome
☐ 256.4 Polycystic ovarian syndrome
☐ Other ____________________________

MEDICAL STATUS AND / OR COMPLICATIONS:

☐ Newly diagnosed
☐ New to Insulin
☐ New to oral anti-diabetes agents
☐ Severe hypo/hyperglycemia
☐ Nephropathy
☐ Retinopathy
☐ Neuropathy
☐ Vascular Disease
☐ Hyperlipidemia
☐ Obesity
☐ Other ____________________________
☐ 1:1 session required. Patient unable to benefit from group class due to impairment of sight, speech, language, hearing; cognitive, physical or emotional limitations. (Circle descriptor.)

PLAN OF CARE: Please check desired component

☐ **Diabetes Self-Management (8 hours)** ☐ **Group Classes in Spanish**

Includes : Assessment and Behavior Change (2 hrs), Diabetes Self-Management Core (4 hrs), Meal Planning (2 hrs)

Additional Modules Offered (1 hour each unless otherwise noted): (typically selected along with, but may be selected independently of Diabetes Self-Management program)

☐ Nutrition and CHO counting – 1 (2 hrs.)
☐ Nutrition and CHO counting – 2 (Follow-up)
☐ Self-blood glucose monitoring
☐ Byetta® initiation (1.5 hours) dose and time: ________________________________
☐ Symlin® initiation (1.5 hours) dose and time: ________________________________
☐ Insulin initiation (1.5 hours): Insulin type(s), dose(s), and time: ________________________________ ________________________________

Patient to continue oral medications? ☐ Yes ☐ No

Medical Nutrition Therapy Orders: ☐ _______Calorie level ☐ _______ CHO ratio ☐ _______ grams protein
☐ Dietitian to determine calories ☐ Dietitian to determine insulin to CHO ratio ☐ Other__________________

☐ **Follow up education** – for patients who complete initial ed (Medicare only: limit 2 hours maximum annually)

☐ **Consider referral for Bariatric Surgery**

DESIRED PLASMA GLUCOSE RANGE:

☐ Pre-prandial: 90-130 mg/di (Non-preg adult)
☐ Post-prandial: less than 180 mg/dl (Non-preg adult)
☐ Pre-prandial:________-________mg/dl
☐ Post-prandial: less than ____________mg/dl

RECENT RESULTS:	A1C____________ Date____________	Blood Pressure________ Date________________	Cholesterol _______ LDL _______ HDL _______ Trig _______ Date_____________

☑ **In case of hypoglycemia, follow outpatient hypoglycemia treatment plan.**

*****THIS ORDER IS FOR UP TO 10 HOURS OF EDUCATION AND 2 FOLLOW-UP GOAL EVALUATION SESSIONS*****

Physician Signature: ____ **Date:** _____________ **Phone:** __________________

Please **fax completed form to** 713-285-1224 • Telephone Number 713-527-5520

PHYSICIAN ORDER

Diabetes Outpatient Education Services

PPH2387 (4/09)

Patient Label