

Great Lakes Diabetes Institute

Excellence in Education and Technology

Phone: (814) 877-2123 • (800) 765-0655 • Fax: (814) 877-5260
1700 Peach Street, Erie PA 16501

Physician Order: Diabetes Self Management Training

Name: _____ Phone: _____
Mailing address: _____ Date of Birth: _____
Billing address (if different than above): _____ SS #: _____
Referring physician: _____ PCP: _____
Insurance/Primary: _____ ID#: _____ Secondary: _____ ID#: _____
Authorization #: _____

Note to Physician: The following information is required for diabetes outpatient education reimbursement and by various regulatory agencies, payers, and/or insurance companies. A meal plan will be offered to all participants.

Physician's Diagnosis:

Type 1 uncontrolled 250.03

Type 2 uncontrolled 250.02

Gestational 648.80

Education to include:

- Monitor @ FBS & 1 hr PP 2 hr PP
- Ketone testing
- Insulin administration:
Pen _____ or Vial and Syringe _____

Pre-Diabetes 790.29 (may not be reimbursed)
(IFG 790.21 and IGT 271.3)

Education to include: nutrition and exercise

Medical Conditions:

- Newly diagnosed
- New to insulin
- New to oral anti-diabetes agents
- Severe hypoglycemia or hyperglycemia occurring during the past year requiring ED visit or hospitalization

Hospital D/C Date: _____

Other: _____

Complications: _____

- Patient unable to benefit from group, class due to impairment of speech, language, sight or hearing.
Consult with Nurse Dietitian

Plan of Care:

- Assessment (includes introduction to Behavior Change)**
- Core Diabetes Education** (based on ADA guidelines)
 - disease process -goal setting/problem solving
 - risk reduction -physical activity
 - monitoring -acute complications
 - medications -nutrition management
 - psychosocial adjustment

Optional Modules

(follow-up or if not getting Core education):

- Basic meal planning Standards of care
- The exchange list Carbohydrate counting
- Weight management Hyperlipidemia
- Advanced Evaluation of BG Controls (CGMS)
- Insulin Pen Type _____ Dosage _____

Lab Results (please complete below or fax results):

Diagnosis made with FBS _____ mg/dl and FBS _____ mg/dl
Or random blood sugar of _____ mg/dl
HbA1C _____ Date _____
Lipid Profile: Cholesterol _____ HDL _____ LDL _____
Triglycerides _____ Date _____

In case of hypoglycemia, follow GLDI treatment protocol.

Technology Prescription (Rx):

(Must be completed for patient to receive equipment.)

BG Monitor w/education & 1 month test strips/lancets
Monitoring frequency _____ times/day

Desired BG: Fasting (90-130 mg/dl) or _____
2 hr pp (<160 mg/dl) or _____

Insulin Pump / Training & Education
Pump Type _____ (if known)
Infusion Set Type _____

Start Upgrade C-Peptide _____ Date _____

Physician Signature

Date

For monitor & instruction, complete the Tech Rx.

Please Fax Form to: (814) 877-5260