

1700 Peach Street, Erie PA 16501  
303 Chestnut Street, Meadville PA 16335  
2060 North Pearl Street, North East PA 16428  
4372 Route 6, Kane, PA 16735

Phone: (814) 877-2123 Fax: (814) 455-9440



### Physician Order: Diabetes Self Management Training

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Mailing address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Referring physician: \_\_\_\_\_ PCP: \_\_\_\_\_  
Insurance/Primary: \_\_\_\_\_ ID#: \_\_\_\_\_ Secondary: \_\_\_\_\_ ID#: \_\_\_\_\_

**Physician's Diagnosis:**

- Type 1 uncontrolled 250.03**
- Type 2 uncontrolled 250.02**
- Pre-Diabetes 790.29** (IFG 790.21 and IGT 271.3)  
(Insurance coverage varies.)
- Reactive Hypoglycemia 251.2** (Not reimbursed by insurance.)
- Gestational 648.80**  
Education to include:
  - Monitor @ FBS &  1 hr PP \_\_\_\_\_  2 hr PP \_\_\_\_\_
  - Ketone testing

**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: \_\_\_\_\_

**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 DI treatment protocol.

**Special Conditions:**

**Education Plan of Care:**

- Comprehensive Diabetes Education**

**Other Education Options:**

- Basic Meal Plan ONLY**
- Carbohydrate Counting ONLY**
- Refresher Course** (Patient received previous diabetes education.)
- Intensive Insulin Management (basal/bolus)**
- Continuous Glucose monitoring/evaluation (iPro/Dexcom)**
- Hyperlipidemia**
- Weight management**
- Injectible: Method \_\_\_\_\_ Type \_\_\_\_\_ Dosage \_\_\_\_\_**
- Insulin: Method \_\_\_\_\_ Type \_\_\_\_\_ Dosage \_\_\_\_\_**
- Insulin Pump Training**  **Advanced Pump Training**

**Other**

- Glucose Sensor:**  **RTS**  **Guardian**  **Dexcom**
- Insulin Pump**  
Pump Type \_\_\_\_\_ (if known)

Notes:

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Physician/Provider Name (Print)

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Physician/Provider Signature

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License # \_\_\_\_\_ Date \_\_\_\_\_

**Fax form to: (814) 455-9440**