Diabetes Services

SERVICE REQUISITION FORM

Fax: 541-966-0504 Phone: 541-278-3249

DIABETES

Patient Information

Patient Name: ______________________ DOB: ______________ Male: ☐ Female: ☐

Address: ______________________________________ City: ______________

State: ______ Zip: ______________ Phone/Contact #: ______________

Insurance Information

Patient Insured : ☐ Yes ☐ No

Primary Insurance: ______________ Group #: __________ Policy #: __________

Authorization Required: ☐ Yes ☐ No Authorization #: ______________

Secondary Insurance: ______________ Group #: __________ Policy #: __________

Physician Information

Ordering Physician Name: ______________________ Phone/Contact #: ______________

Service Information

Diagnosis:

- ☐ Type 1 diabetes mellitus
- ☐ Type 2 diabetes mellitus
- ☐ Gestational diabetes

IDC-10: ____________________

Complications: *(Check all that apply)*

- ☐ Chronic kidney disease
- ☐ Congestive heart failure
- ☐ Hyperlipidemia
- ☐ Gastroparesis
- ☐ Hypertension
- ☐ Neuropathy
- ☐ Obesity
- ☐ Pregnancy
- ☐ Retinopathy
- ☐ Other:____________________

Recent Labs: *(or attach copy)* **Date:** ______________

A1C	Total Cholesterol	LDL	HDL	Triglycerides	Microalbumin	Creatinine	GFR

Please attach medications, medical history, and chart notes related to the referral.

Treatment Plan: *(Check all that apply)*

Diabetes Self-Management Education (DSME):

☐ Initial DSME Training *[10 hours or _____ no. hours requested]*

Patient has special need(s) to receive individual instruction.

- ☐ Vision
- ☐ Hearing
- ☐ Cognitive Impairment
- ☐ Language Limitations
- ☐ Physical
- ☐ Other ____________

☐ Follow-up Training *[2 hours or ______ no. hours requested]*

☐ Insulin Training:

☐ Pen ☐ Syringe ☐ Pump

Medical Nutrition Therapy (MNT):

(MNT can be ordered in addition to DSME)

☐ Initial MNT *[3 hours or _____ no. hours requested]*

☐ Follow-up MNT *[2 hours or _____ no. hours requested]*

☐ Additional MNT in same calendar year
(Please specify change in diagnosis, medical condition, or treatment regimen)

____

Referral valid from ___________ to ____________. If not specified, referral will be valid for 90 days.

CDE to adjust Insulin/Medications: ☐ **Yes** **No**

Authorized Signature

Ordering Physician Signature: ______________________________ Date: ______________

Office Use

Patient Scheduled: ______________________________ CPT Code: ______________