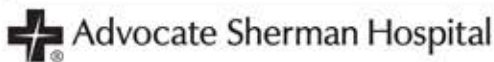


DATE: _____
 PATIENT NAME: _____
 BIRTH DATE: _____
 TELEPHONE #: _____
 ALTERNATE #: _____
 SYMPTOMS; DX DIABETES 250.00; _____
 Fax Results: () _____
 Call Results: () _____

PHYSICIAN NAME PRINT OR STAMP: _____
 PHYSICIAN SIGNATURE: _____
 Non-Staff MD NPI: _____
 Address and Telephone: _____
 Add'l. Result Copies To: _____

<p>Primary Diabetes Indication:</p> <p><input type="checkbox"/> Type I <input type="checkbox"/> Type II Diet Controlled <input type="checkbox"/> Type II Insulin Requiring <input type="checkbox"/> Type II Oral Agent <input type="checkbox"/> Gestational <input type="checkbox"/> Pre-existing DM; Pregnancy <input type="checkbox"/> Impaired Glucose Tolerance; Impaired Fasting Glucose <input type="checkbox"/> Pre-diabetic</p>	<p>Diabetes Lab Results: (Please provide lab values)</p> <p>FBS _____ mg/dl _____ (date) HgbA1C _____ % _____ (date) Microalbumin _____ mg/24hr, ug/min, ug/mg _____ (date) Cholesterol _____ mg/dl _____ (date) LDL _____ mg/dl _____ (date) HDL _____ mg/dl _____ (date) Triglycerides _____ mg/dl _____ (date)</p>
<p>Additional Information:</p> <p>A. Poorly Controlled Diabetes*</p> <p><input type="checkbox"/> Recurrent elevated blood sugars (fasting glucose >140 mg/dl or recurrent random glucose >180mg/dl or HgbA1C > 7%) <input type="checkbox"/> Recurrent hypoglycemia <input type="checkbox"/> Recent hospitalization for DKA or HHNS indicating need for supplemental diabetes self-management training <input type="checkbox"/> Recurrent utilization of diabetes services via emergency room, hospital, home health service, physician office, or clinic visit.</p> <p>*American Diabetes Association Guideline</p> <p>B. New Diagnosis <input type="checkbox"/> Newly Diagnosis Diabetes</p> <p>C. Diabetes Complications</p> <p><input type="checkbox"/> Cardiovascular <input type="checkbox"/> Dermatopathy <input type="checkbox"/> Foot Disease <input type="checkbox"/> Gastroparesis <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Hypertension <input type="checkbox"/> Nephropathy <input type="checkbox"/> Neuropathy <input type="checkbox"/> PVD <input type="checkbox"/> Retinopathy <input type="checkbox"/> Other _____</p> <p>D. Existing barriers that impede patient's ability to obtain diabetes self-management skills through routine physician office training.</p> <p><input type="checkbox"/> Non-compliance <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Impaired Dexterity <input type="checkbox"/> Impaired Mental Status <input type="checkbox"/> Impaired Mobility <input type="checkbox"/> Impaired Psychosocial Status <input type="checkbox"/> Learning Disability <input type="checkbox"/> Visual; Hearing Impairment <input type="checkbox"/> Other: _____</p>	<p>Management Skills</p> <ul style="list-style-type: none"> <input type="checkbox"/> CGMS (3-day continuous glucose monitoring sensor) <input type="checkbox"/> Comprehensive Management Skill Class (Insulin) <input type="checkbox"/> Comprehensive Management Skill Class (Oral Agents) <input type="checkbox"/> Control with Insulin Management <input type="checkbox"/> Control with Oral Medications <input type="checkbox"/> Exercise Management through Cardiac Rehabilitation <input type="checkbox"/> Management of Diabetes During Pregnancy <input type="checkbox"/> Management of Obesity/Weight loss in Type II DM <input type="checkbox"/> Nutrition Management <input type="checkbox"/> Self Blood Glucose Monitoring <input type="checkbox"/> Other: _____ <p>Medications:</p>



**OUTPATIENT DIABETES
 MANAGEMENT ORDER FORM**

