DIABETES EDUCATION ORDER FORM

Fax to Diabetes Program: (510) 739-0687

Date:____________

1PO

PATIENT INFORMATION

Last name:_________________________ First: _________________________

Date of birth: ____________ SSN: ____________ Home phone: _________________________

Address: _________________________ Work phone: ____________ Cell:___________

City: ____________________ Zip: _________ Primary Language: ____________________

DIAGNOSIS ***(check all that apply)***

☑	ICD-9	Type of diabetes:	☑	ICD-9	Other:
	250.02	Type 2		791.0	Microalbuminuria
	250.03	Type 1		585	Renal Disease (non-dialysis)
	648.83	Gestational Diabetes (GDM)		362.02	Retinopathy
	648.03	Pregnancy (with type 1 or 2)		536.3	Gastroparesis
		Other:		357.2	Peripheral Neuropathy
	401.9	Hypertension		414.8	Chronic Ischemic Heart Disease
	272	Hyperlipidemia		436	CVA
	Other:			250.11	DKA: Diabetic Ketoacidosis

Sweet Success Program for Gestational Diabetes (GDM)

☐ Oral Glucose Tolerance date _______, results (mg/dl): fasting ____; 1 hour ____; 2 hour ____; 3 hour ____
If glucose patterns above target / high risk range, refer to first available endocrinologist or: _______ ,M.D.

- Perform / follow-up with 6 week postpartum Oral Glucose Tolerance Test (2 hour 75-gm glucose)

Other orders: ______________________________________

DIABETES SELF-MANAGEMENT TRAINING (DSMT) BASICS PROGRAM

☐ Complete Diabetes Program *(10 hours/national standard content areas)*

☐ Patients with special needs requiring Individual DSMT, ***must check special need(s):***
___Language, ___Vision, ___Hearing, ___Physical, ___Cognitive, ___ Schedule,___ Other: _______

☐ Medication Instruction
Orals: antidiabetic(s): ______________________________
Insulin: stop oral medications? ____Yes ____No
Start Insulin or other: ______________________________

☐ Insulin Pump: ___ Assess readiness ___ Determine insulin sensitivity/carb ratio ___ Start pump

☐ 2 hours annual DSMT (after initial 10 hours DSMT completed)

DIABETES MEDICAL NUTRITION THERAPY (MNT) ***(for non-diabetic patients, call 510-745-6597)***

☐ Initial MNT (3 hours) ☐ Annual follow-up MNT (2 hours annually)

☐ Additional MNT services in the same calendar year: ___ number additional hours requested
Required: specify change in medical condition, or treatment: ____________________

ATTACH COPIES OF RECENT LABS: glucose, A1C, Chem Panel, and lipids if available.
Perform A1C on initial assessment and capillary glucose as needed;
For non-GDM patients, perform urine microalbumin and a 3-month follow-up A1C.

PHYSICIAN NAME: ____________________ **SIGNATURE:** ____________________

Address: ______________________________ City: ____________ Zip: _______

Phone: ____________________ Fax: ____________________ UPIN # ____________________

11482 ODE 1594 (8/28/08) INTRANET

PATIENT LABEL

Washington Hospital Healthcare System
Washington Township Healthcare District
2000 Mowry Avenue, Fremont, California 94538-1716 • (510) 797-1111

DIABETES SERVICES REFERRAL
1860 Mowry Ave, Suite 200 Fremont, CA 94538
Telephone 510-745-6556