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 (5/17/10) INTRANET

Washington Hospital Healthcare System

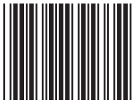
2000 Mowry Avenue, Fremont, California 94538-1716 • (510) 797-1111

DIABETES SERVICES REFERRAL

3575 Beacon Ave., Fremont, CA 94538

Telephone 510-745-6556

5/17/10
W004 / 11482
36



1PO

File Specification Information

Document Size	Gripper / Lock-Up	Stub	Imprint
8.5x11	all	n	n
Punch	**Numbering**	**Binding**	**Registering Plys**
N	n	n	n
Screens	**Backer(s) and Percentage**		
Y - 5%	n		
Color(s)			
blk			
File Information / Master Page			
Other			