



# Diabetes Services Order Form

Patient's Name \_\_\_\_\_  
 Phone # \_\_\_\_\_ DOB \_\_\_\_\_  
 Insurance \_\_\_\_\_  
 Provider's Name \_\_\_\_\_  
 Phone # \_\_\_\_\_ Fax # \_\_\_\_\_  
 Date \_\_\_\_\_  
 Insurance authorization number (if required) \_\_\_\_\_

## DIABETES SELF-MANAGEMENT TRAINING (DSMT)

### Sessions [G0109/98962]

- Complete DSMT Program (10 hrs)  
 Session 1 – Individual Assessment (1 hr)  
 Session 2 – Monitoring Blood Glucose & Meal Planning (3.5 hrs)  
 Session 3 – Exercise/Medications/Travel/Sick Days/Meal Review (3.5 hrs)  
 Session 4 – Complications of Diabetes and Support Resources (2hrs)
- Individual training required due to: \_\_\_\_\_

## CURRENT DIABETES MEDICATIONS / ADMINISTRATION

Specify type, dose and frequency

- Oral: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- Insulin: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- Patient now uses:  Pen  Vial & Syringe  Pump

## LAB RESULTS – please attach to signed order (required)

- Hemoglobin A1c: \_\_\_\_\_
- Fasting blood glucose results ( $\geq 126$ ) on two separate occasions  
 -OR-  
 Two-hour post glucose challenge ( $\geq 200$ ) on two separate occasions  
 -OR-  
 Random glucose test  $> 200$  with symptoms of diabetes

## DIAGNOSIS, COMPLICATIONS, COMORBIDITIES & BARRIERS

Check all that apply:

- Newly Diagnosed Type 2  Uncontrolled Type 2
- Hypertension  Dyslipidemia  Stroke  
 Neuropathy  Nephropathy  PVD  
 Renal Disease  Retinopathy  CHD  
 Obesity  Pregnancy  Non-healing wound  
 Low Literacy  Language Barrier  Visual/hearing impairment  
 Social Status  Impaired Dexterity  Learning Disability  
 Mental/affective disorder  
 Other \_\_\_\_\_

Please specify any change in medical condition, treatment, and/or diagnosis. Attach appropriate documentation.

- Patient needed ER visits or hospitalization  
 Lack of feeling in foot or other foot complication such as foot ulcers, deformities, or amputations.  
 Pre-proliferative / proliferative retinopathy or prior laser treatment of eye.  
 Kidney complications related to diabetes manifested by albumin without other causes or elevated creatinine.  
 Other \_\_\_\_\_

Provider Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ UPIN \_\_\_\_\_ Date \_\_\_\_\_

Practice Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

### - PARTICIPATING DIABETES OUTPATIENT TRAINING SITES -

**Bayside Community Hospital**  
 200 Hospital Dr., Anahuac, Tx 77514  
 Ph- 409-267-3143 Fax- 409-267-3608

**Columbus Community Hospital**  
 110 Shult Dr., Columbus, TX 78934  
 Ph- 979-732-2371 Fax- 979-732-6289

**Lavaca Medical Center**  
 1400 N. Texana, Hallettsville, TX 77964  
 Ph- 361-798-3671 Fax- 361-798-5829

**Brazosport Regional Health System**  
 100 Medical Dr., Lake Jackson, TX 77566  
 Ph- 979-285-1188 Fax- 979-299-2824

**El Campo Memorial Hospital**  
 303 Sandy Corner Rd., El Campo, TX 77437  
 Ph- 979-543-6251 Fax- 979-578-5265

**Matagorda Regional Medical Center**  
 104 7<sup>th</sup> Str., Bay City, TX 77414  
 Ph- 979-245-6383 Fax- 979-241-3667