ORDERS

OUTPATIENT DIABETES PROGRAM

2 Upper Ragsdale Dr., Building D, Suite 200, Monterey, CA 93940
(831) 649-7220
FAX to Diabetes Program (831) 649-7221

Patient name ______________________ DOB ____________ ☐ Male ☐ Female
Home phone ______________ Work/cell phone ______________ ht _____ wt _____
Address ____
Insurance ______________________ Group/ID number ______________

☒ **Perform HgbA1C on initial assessment and three-month follow up, capillary glucose, and urine microalbumin as needed.**

Diagnosis

☐ Type 1 uncontrolled ☐ Type 1 controlled ☐ Type 2 uncontrolled ☐ Type 2 controlled ☐ Other ____________

Complications/Co-morbidities

☐ Hypertension ☐ Dyslipidemia ☐ Stroke ☐ Neuropathy ☐ Nephropathy
☐ PVD ☐ Gastroparesis ☐ Retinopathy ☐ CVD ☐ Non-healing wound
☐ Obesity ☐ Mental/affective disorder ☐ Other ______________

Indicate barriers requiring customized education

☐ Language ☐ Impaired mobility ☐ Impaired vision ☐ Impaired hearing ☐ Eating disorder
☐ Impaired dexterity ☐ Impaired mental status/cognition ☐ Other ______________

Reason for Referral (check all that apply):

- **Diabetes Self Management Education (DSME)**
  - ☐ Comprehensive Program (includes 10 hour DSME, RD Medical Nutrition Therapy & RN follow up as needed)
  - ☐ Ten hour DSME only
  - ☐ Follow-up DSME (Medicare benefit 2 hrs for all years after inital year of education)
  - ☐ Self Monitoring Blood Glucose (SMBG) Instruction
  - ☐ Pre-conception Education ☐ Other ______________
- **Medical Nutrition Therapy**
  - ☐ Initial ☐ Follow-up (Medicare benefit 2 hrs for all years after inital year of education)
- **RN Services**
  - ☐ Insulin / GLP-1 instruction: Specify medication ______________ dose _____ frequency _____
  - ☐ Continuous Glucose Monitoring ☐ Insulin pump instruction
  - Other ______________
- **Nurse Practitioner services**
  - ☐ DM Management (prescription can include DM medications and DM related equipment only)
  - May include: ☐ Insulin/GLP-1 ☐ CGM ☐ Insulin pump start and management

Additional comments

Attach labs if available

☐ I hereby certify that I am managing this beneficiary's diabetes condition and that the above prescribed training is a necessary part of management. (Medicare patients)

Physician's office number ______________ Fax ______________

_______ _______ ______________ ______________
Time Date Physician signature Print physician full name

Community Hospital of the Monterey Peninsula®

OUTPATIENT DIABETES PROGRAM REFERRAL

922091/7072 (6/14)