



Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

1963 Memorial Parkway SW • Huntsville Hospital Medical Mall • Huntsville, AL 35801
Physicians please fax referral to (256) 801-6222 to schedule. Patients may call (256) 801-6283 to schedule.

Diabetes Self-Management Education/Training Services Order Form

Patient name:

Patient address:

Phone #:

City:

State:

Zip:

\*Insurance:

Group #:

DOB:

\*New diagnosed patients: Medicare requires documentation of fasting blood glucose >=126mg/dl on 2 separate occasions or 2 hour post-glucose challenge >=200mg/dl or random glucose test >200 mg/dl for person with symptoms of uncontrolled diabetes.

PLEASE INDICATE NEED FOR DIABETES SELF-MANAGEMENT TRAINING BELOW

[ ] Newly diagnosed 10hrs. [ ] Change in condition/treatment regimen \_\_\_\_\_

[ ] Group instruction: 10hrs. [ ] Follow up diabetes training: 2hrs per calendar year

Reason for 1:1 instruction: [ ]Language [ ]Impaired hearing/sight [ ]Cognitive impairment [ ]Physical [ ]Additional hrs requested \_\_\_\_\_

Please check diagnosis

[ ] E11.65 Type 2 diabetes mellitus with hyperglycemia

Does patient take insulin/other injectables? [ ]Yes [ ] No

[ ] E10.65 Type 1 diabetes mellitus with hyperglycemia

Take oral diabetes meds? [ ]Yes [ ] No Wear insulin pump? [ ]Yes [ ]No

Other diabetes diagnoses \_\_\_\_\_

[ ] Prediabetes/Impaired Fasting Glucose Note: Patient will be billed directly for non-diabetes diagnosis

[ ] Dietitian to determine meal plan/ calorie needs Comment \_\_\_\_\_

Comorbidities: [ ]Hypertension [ ]Dyslipidemia [ ]Other \_\_\_\_\_ Comment: \_\_\_\_\_

Please check how often patient needs to test their blood glucose

[ ] 1 time a day [ ] 2 times a day [ ] 3 times a day [ ] 4 times a day Other \_\_\_\_\_

Hemoglobin A1C \_\_\_\_\_ Date \_\_\_\_\_

BMP Glucose Result \_\_\_\_\_ Date \_\_\_\_\_ BMP Glucose Result \_\_\_\_\_ Date \_\_\_\_\_

Physician's signature: \_\_\_\_\_ NPI# \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Physician's name (printed): \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physician offices please call (256) 265-3069 if you have any questions.

