CHI St. Anthony Hospital

Diabetes Services

SERVICE REQUISITION FORM

Fax: 541-966-0504 Phone: 541-278-3249

DIABETES

Patient Information

Patient Name: _____ DOB: _____ Male: ☐ Female: ☐

Address: _____ City: _____

State: _____ Zip: _____ Phone/Contact #: _____

Insurance Information

Patient Insured : ☐ Yes ☐ No

Primary Insurance: _____ Group #: _____ Policy #: _____

Authorization Required: ☐ Yes ☐ No Authorization #: _____

Secondary Insurance: _____ Group #: _____ Policy #: _____

Physician Information

Ordering Physician Name: _____ Phone/Contact #: _____

Service Information

Diagnosis:

- ☐ Type 1 diabetes mellitus
- ☐ Type 2 diabetes mellitus
- ☐ Gestational diabetes

IDC-10: _____

Complications: *(Check all that apply)*

- ☐ Chronic kidney disease
- ☐ Congestive heart failure
- ☐ Hyperlipidemia
- ☐ Gastroparesis
- ☐ Hypertension
- ☐ Neuropathy
- ☐ Obesity
- ☐ Pregnancy
- ☐ Retinopathy
- ☐ Other:_____

Recent Labs: *(or attach copy)* **Date:** _____

A1C	Total Cholesterol	LDL	HDL	Triglycerides	Microalbumin	Creatinine	GFR

Please attach medications, medical history, and chart notes related to the referral.

Treatment Plan: *(Check all that apply)*

Diabetes Self-Management Education (DSME):

☐ Initial DSME Training *[10 hours or ____ no. hours requested]*

Patient has special need(s) to receive individual instruction.

- ☐ Vision
- ☐ Hearing
- ☐ Cognitive Impairment
- ☐ Language Limitations
- ☐ Physical
- ☐ Other _____

☐ Follow-up Training *[2 hours or _____ no. hours requested]*

☐ Insulin Training:

- ☐ Pen
- ☐ Syringe
- ☐ Pump

Medical Nutrition Therapy (MNT):
(MNT can be ordered in addition to DSME)

☐ Initial MNT *[3 hours or ____ no. hours requested]*

☐ Follow-up MNT *[2 hours or ____ no. hours requested]*

☐ Additional MNT in same calendar year
(Please specify change in diagnosis, medical condition, or treatment regimen)

_____

Referral valid from _____ to _____. If not specified, referral will be valid for 90 days.

CDE to adjust Insulin/Medications: ☐ **Yes** ☐ **No**

Authorized Signature

Ordering Physician Signature: _____ Date: _____

Office Use

Patient Scheduled: _____ CPT Code: _____