PLEASE FAX THIS FORM TO 402-481-6361

PATIENT INFORMATION

Name: _____

Address: _____

_____
City State Zip

_____
Date of Birth Home Number

_____
Work Number Cell Number

Patient Insurance _____

PATIENT MUST HAVE SPECIAL NEED(S) TO RECEIVE INDIVIDUAL INSTRUCTION (CHECK ALL SPECIAL NEEDS THAT APPLY)

- ☐ Visual
- ☐ Physical
- ☐ Hearing
- ☐ Emotional
- ☐ Learning
- ☐ Language _____
- ☐ Other _____

THE FOLLOWING CRITERIA ARE REQUIRED FOR REIMBURSEMENT:

☐ **New Diagnosis** (within last 12 months)
- ☐ Fasting blood sugar ≥ 126 **(2 required)**
  ____mg/dl date ____/____/____ and ____mg/dl date____/____/____
- ☐ 2-hour post-glucose challenge ≥200
  ____mg/dl date ____/____/____
- ☐ Random glucose test >200 with signs/symptoms of diabetes

☐ **Established diagnosis** (> 12 months)

DIAGNOSIS (check appropriate boxes)

- ☐ Type 1 Controlled ☐ Type 1 Uncontrolled
- ☐ Type 2 Controlled ☐ Type 2 uncontrolled
- ☐ Steroid Induced

- ☐ Gestational Diabetes Education
- ☐ GTT Values; FBG_____
  1° _____ 2° _____ 3° _____
  glucose load _____

CURRENT DIABETES MEDS - DOSE & TIME

Insulin Regimen _____

Oral Agents _____

LABS (most recent) (Complete or attach labs for outcomes evaluations)						
	A1c	_____	Date:	_____	Cholesterol_____	Lipids Date:_____
	Creatinine	_____	Date:	_____	Triglycerides_____	
	Microalbumin	_____	Date:	_____	HDL_____	
					LDL_____	

MD ORDER (Check services being ordered)

- ☐ Diabetes Assessment and Education
- ☐ Medical Nutrition Therapy (MNT)
- ☐ Foot Care
- ☐ Other _____

Your patient will be evaluated by a Certified Diabetes Educator for their education needs and placed in the appropriate class (or classes).

_____ _____ _____
Physician Signature (required) Physician ID Number Date/Time

Bryan Medical Center
Lincoln, NE

BRYAN LIFEPOINTE CLINICAL SERVICES
DIABETES CENTER
REFERRAL ORDER

DTM0033

Place Patient Label Here