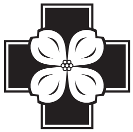

ST. JOSEPH
Regional Medical Center

415 6th Street
Lewiston, Idaho 83501

Diabetes Center
Provider Referral/Order

Phone: (208) 799-5273

FAX COMPLETED FORM TO: (208) 799-6520

Patient Name:__________________________ DOB:____/____/____

Contact Phone ( )__________________________ Work Phone ( )__________________________

Insurance type:__________________________ Referring care provider:__________________________

1. (REQUIRED as available) ____________________

Labs: FBS ____________________ Date:____________

(or 2 hr GTT) ____________ Date:____________

Hgb A1C________________ Date:____________

Lipid Profile (if available):

HDL ____________________ Date:____________

LDL____________________ Date:____________

Cholesterol ________________ Date:____________

Triglycerides ______________ Date:____________

Medications: (Okay to attach to sheet) ____

Activity/Exercise Restrictions:____

2. Diagnosis: (please check appropriate diagnosis)

- ☐ Type 1 DM, new diagnosis
- ☐ Type 1 DM, uncontrolled

3. Instruct Patient as Follows:

- ☐ Diabetes self management education (includes basic nutrition)
- ☐ Blood glucose monitoring
- ☐ Insulin instruction/Pump therapy (Provider can contact Diabetes Center for insulin initiation form)
- ☐ Continuous glucose monitor instructions

Comments: ____

For Medicare, individual instruction (1:1) for Diabetes self management education is a covered benefit only if the patient has at least one of the following conditions present:

- ☐ Severe vision limitations
- ☐ Severe hearing limitations
- ☐ Cognitive limitations
- ☐ Severe language limitations
- ☐ No group session is available within 2 months of the date the training is ordered
- ☐ Additional insulin therapy

4. As the health care provider treating this beneficiary's diabetes, I certify that diabetes self management training is needed under a comprehensive plan of care.

Referred by:____ Date:________________

(Provider Signature)

I agree to release pertinent labs and information pertaining to my diagnosis for 1 year from today's date.

____ ______________________

Patient Signature **Date**

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