

Patient Label



**\*\*Please Fax to (757) 261-6791\*\***

I am referring:  
 Patient Name \_\_\_\_\_ DOB \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_  
 Weight \_\_\_\_\_ Height \_\_\_\_\_  
 Insurance Name \_\_\_\_\_ Authorization # \_\_\_\_\_ Number of Visits \_\_\_\_\_  
 Visit Start & End dates \_\_\_\_\_  
 For the necessary Diabetes out-patient self-management program:  
 Diabetes Diagnosis:  Type 1  Type 2  IGT  Other \_\_\_\_\_  
 Recent HgbA1c: \_\_\_\_\_ Date: \_\_\_\_\_ (Attach any pertinent lab work)  
 Blood Glucose Target Range: \_\_\_\_\_

**GROUP EDUCATION**

**Health Living with Diabetes:** Comprehensive Group program – 9 hours of class includes: Individual Assessment, Understanding Diabetes / Complications / Foot Care / Community Resources / Nutrition Management / Changing Habits / Sick Day Management / Medication / Monitoring / Exercise / Stress / Goal Setting

**INDIVIDUAL SESSIONS**

**Insulin Start:** Preparation / Self Injection / Prevention / Treatment of Low / High Blood Sugar  
 Insulin type: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

**Use of Blood Glucose Meter:** Operation of Meter, Obtaining Sample of Capillary Blood, Record Keeping, Individualized Meal Plan

**Intensive Management (2 Hours)**  
 Includes Advanced Carbohydrate Counting & Insulin Adjustment Training

Physician Signature \_\_\_\_\_ Date/Time \_\_\_\_\_

Physician Name – please print \_\_\_\_\_

Address \_\_\_\_\_ Tel # \_\_\_\_\_ Fax # \_\_\_\_\_

**Outpatient Reimbursement Criteria (For Insurance Reimbursement)**

The criteria below has been developed as a guideline to validate the need for supplemental diabetes self-management training above and beyond the usual, reasonable, and necessary training provided by the physician.

**(Mark one or more of the following reasons for patient referral)**

- A. Poorly Controlled Diabetes or New Onset Diabetes
- Recurrent elevated blood glucose (fasting glucose > 126 mg/dL, recurrent random glucose >200 mg/dL; or HgbA1c>6.5).
  - Recurrent Hypoglycemia or Hyperglycemia Unawareness.
  - Recent Hospitalization for DKA or HHNK indicating need for supplemental diabetes self management training.
  - Recurrent utilization of diabetes services via emergency room, hospital, home health services, physician office or clinic visit.
  - Non-compliance to recommended regimen
  - Other: \_\_\_\_\_
- B. Diabetes Complications
- Retinopathy       Neuropathy       Pregnancy       Nephropathy
  - Dermatopathy       Hyperlipidemia       Hypertension       Cardiovascular Disease
  - Other \_\_\_\_\_
- C. Existing barriers that impede the patient's ability to obtain diabetes self-management skills through routine physician office training:
- Learning Disability       Visual Impairment       Impaired Psychosocial Status       Impaired Dexterity
  - Impaired Mobility       Morbid Obesity       Eating Disorders       Low Literacy
  - Impaired Hearing       Other \_\_\_\_\_

For reimbursement purposes, it is preferred to elaborate on the specific values, severity, and time frames related to any of the above.

**NOTE: PLEASE INITIATE THE PROCESS OF PRIOR AUTHORIZATION FOR THE ABOVE REQUEST, IF SPECIFIED AND REQUIRED BY THE CLIENT'S INSURER(S). THANK YOU**