Prairie Ridge HEALTH
Inspired by you

Outpatient Diabetes Services Referral

PRH Diabetes Services
1515 Park Avenue
Columbus, WI 53925
Phone 920-623-1545

**Indicates required information*

All orders MUST include a copy of the most recent visit note, lab results, vitals and medication list.
Fax completed form to Diabetes Services at 920-623-1250. We will call your patient to schedule.

*Patient's Name _____ *Date of Birth _____

*Full Address _____

*Home/Cell Phone _____ Other Contact Phone/Person _____

*Health Insurance _____ ID# or MRN# _____

*DIAGNOSIS (check ONE diagnosis)

Type 2 Diabetes

- ☐ E11.9 Type 2 diabetes mellitus without complication
- ☐ E11.8 Type 2 diabetes with unspecified complications
- ☐ E11.65 Type 2 diabetes mellitus with hyperglycemia
- ☐ E11.40 Type 2 diabetes mellitus with diabetic neuropathy, unspecified
- ☐ E11.649 Type 2 diabetes mellitus with hypoglycemia without coma
- ☐ E11.21 Type 2 diabetes mellitus with diabetic nephropathy
- ☐ E11.59 Type 2 diabetes mellitus with other circulatory complications

Other *(must include written diagnosis description)*

☐ _____

_____

Type 1 Diabetes

- ☐ E10.9 Type 1 diabetes mellitus without complication
- ☐ E10.8 Type 1 diabetes with unspecified complication
- ☐ E10.65 Type 1 diabetes mellitus with hyperglycemia
- ☐ E10.40 Type 1 diabetes mellitus with diabetic neuropathy, unspecified
- ☐ E10.22 Type 2 diabetes mellitus with diabetic chronic kidney disease

Gestational Diabetes

- ☐ O24.41 Gestational diabetes mellitus in pregnancy
- ☐ O99.810 Impaired glucose tolerance during pregnancy

*MODIFIER (check ONE modifier for type 1 or type 2 diabetes diagnoses)

Insulin/Medication Status Modifier

☐ Z79.4 Long term (current) use of insulin ☐ Without insulin use ☐ Z96.41 Long-term (current) use of insulin pump

*REQUESTED EDUCATION/TRAINING

Coverage for requested services varies by insurance.

- ☐ Initial Diabetes Self-Management Education/Training (Medicare Coverage: 10 hrs initial DSME/T in 12 month period from the date of first class or visit) with Medical Nutrition Therapy (Medicare Coverage: 3 hrs initial MNT in the first calendar year).
- ☐ Annual Follow Up Diabetes Self-Management Education/Training (Medicare Coverage: 2 hrs).
- ☐ Annual Follow Up Medical Nutrition Therapy (Medicare Coverage: 2 hrs).
- ☐ Continuous Glucose Monitoring (professional/personal): sensor placement, hook-up, patient training, removal of sensor and data report.

☒ Individual Education/Training Session(s)--***Check all that apply***

☐ Vision impairment ☐ Hearing impairment ☐ Physical limitations ☐ Language limitations
☐ Cognitive impairment ☐ Individualized insulin training ☒ Other: No group session available within 2 months.

ADDITIONAL ORDERS

- ☐ Diabetes Mellitus Medication Titration per Standing Order/facility treatment guidelines: Yes, HCP has authorized the use of the Standing Order/facility treatment guidelines per this referral. Diabetes educators with prescriptive authority may adjust or add diabetes medications, order labs, and supplies to achieve glycemic control.
- ☐ Insulin pump evaluation, initiation, insulin settings adjustments and follow-up.
- ☐ Determine insulin-to-carbohydrate ratio with correction factor and instruct patient on use.
- ☐ Other: _____

_____

*PLAN OF CARE

☒ Diabetes Services Staff to assess patient's knowledge and provide education as needed. Content areas (per guidelines for an ADA Recognized Program): Describing diabetes pathophysiology and treatment options, incorporating healthy eating into lifestyle, incorporating being active into lifestyle, using medication(s) safely, monitoring glucose and other parameters and interpreting and using the results, preventing, detecting, and treating acute complications, preventing detecting, and treating chronic complications, adapting lifestyle behaviors for healthy coping, recognizing diabetes distress and identifying support options.

*CERTIFICATION STATEMENT

☒ I certify Diabetes Self-Management Education/Training and Medical Nutrition Therapy are needed under a comprehensive plan for this patient's diabetes care.

Physician Signature _____ Date ____/____/____

Physician Name and UPIN#—Please Print _____

Office Contact name: _____ Telephone Number: _____