



Broward General Medical Center 1600 S. Andrews Avenue Fort Lauderdale, FL 33316 (954) 355-5363 • Fax (954) 355-4347	OUTPATIENT DIABETES EDUCATION PROGRAM REFERRAL PRESCRIPTION	
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PT. NAME: _____ PHONE # _____

ICD-9 DIAGNOSIS CODE: _____ DIAGNOSIS DATE (MO/YR): _____

MEDICARE QUALIFYING CRITERIA (NOT REQUIRED FOR HMO/PPO PATIENTS)
PLEASE CHECK ALL THAT APPLY OVER THE PAST 12 MONTHS:
<input type="checkbox"/> NEWLY DIAGNOSED
<input type="checkbox"/> NEW TO ORAL MEDICATION OR NEW TO INSULIN
<input type="checkbox"/> RECURRENT HYPERGLYCEMIA AS EVIDENCED BY HbA1C > 8.5 X 2 TESTS DONE 3 MONTHS APART
<input type="checkbox"/> RECURRENT UTILIZATION OF SERVICES DUE TO DIABETES-RELATED ISSUES (ER OR HOSPITALIZATION DOCUMENTATION REQUIRED)
<input type="checkbox"/> HIGH RISK FOR DOCUMENTED COMPLICATIONS. (PLEASE PROVIDE DOCUMENTATION):
<input type="checkbox"/> RETINOPATHY - PREPROLIFERATIVE, PROLIFERATIVE, OR PREVIOUS LASER THERAPY
<input type="checkbox"/> NEUROPATHY OF LOWER EXTREMITY AS MANIFEST BY NUMBNESS, ULCERATION, DEFORMITY
<input type="checkbox"/> NEPHROPATHY R/T DIABETES, MANIFESTED BY ALBUMINURIA $\bar{5}$ OTHER CAUSE.

PLAN OF CARE:

LIST DIABETES MEDICATIONS AND INDICATE ANY RECENT CHANGES IN TREATMENT PLAN: (ie: oral to insulin, or new to oral meds)

LABS:
HbA1C(recent): _____ DATE: _____ HbA1C > 3MO.AGO: _____ DATE: _____
CHOLESTEROL: _____ HDL: _____ LDL: _____ TG: _____ DATE: _____

EDUCATION PLAN:

- GROUP** OUTPATIENT COMPREHENSIVE DIABETES EDUCATION PROGRAM (INCLUDES NUTRITION EDUCATION)
- INDIVIDUAL (1:1)** INSTRUCTIONS FOR:
 - _____ INSULIN ADMINISTRATION
 - _____ USE OF BLOOD GLUCOSE MONITOR
 - _____ NUTRITIONAL COUNSELING (FOR SPECIAL DIET NEEDS) PLEASE SPECIFY: _____
 - _____ 1:1 COMPREHENSIVE DIABETES INSTRUCTION (**MUST BE MEDICALLY NECESSARY FOR MEDICARE PATIENTS** - PLEASE SPECIFY NECESSITY): _____
 - _____ OTHER (GESTATIONAL, PUMP USE, ETC) PLEASE SPECIFY: _____

***PHYSICIAN SIGNATURE:** _____ **NAME STAMP/PRINT:** _____

DATE: _____

OFFICE PHONE NUMBER: _____ FAX NUMBER: _____

FOR HMO/PPO PATIENTS: PLEASE PROVIDE AUTHORIZATION (IF REQUIRED) FOR 4 VISITS IN 90 DAYS.

INSURANCE CARRIER _____

AUTHORIZATION # _____ AUTHORIZATION EXPIRATION DATE _____