ST. MARY'S HEALTH CARE SYSTEM
A Member of Trinity Health

# OUTPATIENT ORDER FORM
# NUTRITION AND DIABETES EDUCATION

Appt. Date: _____
Appt. Time: _____
Arrival Time: _____

**TO SCHEDULE: 706.389.2700**
FAX this order and required clinical records to: 706.389.2711

☐ **Main Hospital**
1230 Baxter St., Athens, GA

☐ **Outpatient Diagnostic Center**
2470 Daniells Bridge Rd., Athens, GA

☐ **St. Mary's Sacred Heart Hospital**
355 Clear Creek Pkwy., Lavonia, GA

| PATIENT'S LEGAL NAME | DATE OF BIRTH | PATIENT PHONE | INSURANCE COMPANY NAME |
|---|---|---|---|
| | | | |

**PHYSICIAN OFFICES** Tests cannot be performed without listing the signs/symptoms and/or reason(s) for each test ordered along with the ICD-10 Code. code. Federal law requires that inform you when ordering tests that will be paid under federal health programs, including Medicare and Medicaid, physicians should only order tests that are medically necessary for diagnosis or treatment of the patient, not for screening purposes.

**Your office will be contacted prior to test being performed if form is not complete.**

| PATIENT SIGNS/SYMPTOMS | ICD-10 CODE: |
|---|---|
| | |

PHYSICIAN NAME (please print)

☐ CALL REPORT TO _____

☐ FAX REPORT TO _____

X _____ _____
ORDERING PHYSICIAN'S SIGNATURE DATE/TIME
***Signature Stamps Are Not Valid***

MY CLINICAL QUESTION IS:

## APPOINTMENTS NECESSARY FOR EXAMS LISTED BELOW

### PLAN OF CARE:

- ☐ **Comprehensive Program:** DSMT and MNT - up to 10 hours DSMT and 3 hours MNT
- ☐ **Annual Review -** up to 2 hours each DSMT and MNT for individuals who previously attended DSMT and/or MNT
- ☐ **Start new injectable meds**
- ☐ **Insulin Pump**
- ☐ **Continuous Glucose Monitoring**
- ☐ **Blood Glucose Meter instructions**
- ☐ **Gestational Diabetes**
- ☐ **Medical Nutrition Therapy**
- ☐ **Algorithm Adjustment/Intensive Insulin mgmt**
- ☐ Group/Individual Education
- ☐ Diabetes Educator
- ☐ Dietitian

### LAB RESULTS:

Fasting Blood Sugar _____ Date _____
HbA1c _____ Date _____
Microalbumin _____ Date _____
Cholesterol _____ Date _____
Triglycerides _____ Date _____
HDL _____ Date _____
LDL _____ Date _____

### SELF BLOOD GLUCOSE MONITORING

☐ Daily ☐ 2X / Day ☐ 3X / Day ☐ 4X /Day ☐ Other

### REASON FOR REFERRAL:

- ☐ **Diabetes**
  - ☐ New onset date of dx: _____
  - ☐ Tx regimen change
  - ☐ Acute hypo/hyper
  - ☐ High risk complications
- ☐ **Weight**
  - ☐ Obesity BMI: _____
  - ☐ Underweight/malnutrition
  - ☐ Weight loss medications/surgery
- ☐ **Cardiovascular**
- ☐ **Gastrointestinal**
- ☐ **Other** _____

I certify that I am managing the patient's diabetes condition and Diabetes Self-Management (DSMT) and/or MNT is medically necessary. ☐ Yes ☐ No