



ST. JOSEPH

Regional Medical Center

**415 6th Street, Office 3B11
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: _____

<p>1. (REQUIRED as available) _____</p> <p>Labs: FBS _____ Date: _____ (or 2 hr GTT) _____ Date: _____ Hgb A1C _____ Date: _____</p> <p>Medications: (Okay to attach to sheet) _____</p> <p>Activity/Exercise Restrictions: _____</p>	<p>Lipid Profile (if available):</p> <p>HDL _____ Date: _____ LDL _____ Date: _____ Cholesterol _____ Date: _____ Triglycerides _____ Date: _____</p>
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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) Continuous glucose monitor instructions

Blood glucose monitoring

Insulin instruction/Pump therapy (Provider can contact Diabetes Center for insulin initiation form)

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 language limitations

Severe hearing limitations No group session is available within 2 months of the date the training is ordered

Cognitive limitations 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