DeKalb Medical
Tax ID Number: 26-3454827

PS-1053

**Nutrition & Diabetes Education Center Order Form**
FAX orders to: 404.501.1773
Phone: 404.501.1790

## Patient Information (Required for Scheduling)

Patient Name: _____ DOB: _____ Sex: ❑ M ❑ F SS#: XXX-XX-_____
First & Last Name

Patient's Address: _____ _____ _____ _____
Street City State Zip Code

Home Phone #: _____ Mobile Phone #: _____ Email Address: _____

Primary Insurance: _____ Policy #: _____ Group #: _____ Phone #: _____
Plan & Product

Secondary Insurance: _____ Policy #: _____ Group #: _____ Phone #: _____
Plan & Product

## Order Information - Nutrition & Diabetes Education Center

### 1. DIABETES EDUCATION: DIAGNOSIS (TYPE OF DIABETES)

Diagnosis: _____

ICD-CM Codes: _____

### 2. DIABETES EDUCATION: SERVICE REQUESTED

*GROUP EDUCATION IS THE STANDARD UNLESS THERE IS A NEED FOR INDIVIDUAL INSTRUCTION OR NO GROUP CLASS IS AVAILABLE

❑ **Comprehensive Group Diabetes Self-Management Instruction** (1 hour pre-assessment (G0108) and ≤ 9 hours group class (G0109))
**PREFERRED**

❑ Gestational Diabetes (antepartum) Self–Management Instruction (≤ 3 hours, Individual G0108 or Group Class G0109)

❑ Insulin/Other Injectable Self-Administration Training (1 hour: Individual (G0108))
Medication: _____ Dose: _____ Frequency: _____

❑ Individual Diabetes Instruction (2 hours, Individual (G0108)) due to the following existing barrier(s):

❑ Vision ❑ Hearing ❑ Language ❑ Speech ❑ Cognitive ❑ Physical ❑ Other (Please Specify):_____

**CURRENT TREATMENT PLAN**

❑ Diet and Exercise
❑ Oral Medications (Please Specify):
❑ Insulin (Please Specify): _____
❑ Insulin Pump (Please Specify):_____

**ADDITIONAL COMPLICATIONS**

| | | | |
|---|---|---|---|
| ❑ Hypertension | ❑ Hyperlipidemia | ❑ Renal Insufficiency | ❑ End Stage Renal Disease |
| ❑ Neuropathy | ❑ Retinopathy | ❑ Stroke | ❑ Cardiovascular Disease |
| ❑ Sleep Apnea | ❑ Obesity | ❑ Peripheral Vascular Disease | ❑ Recurrent Hypoglycemia |

Other (Please Specify):_____

### 1. MEDICAL NUTRITION THERAPY: DIAGNOSIS (MEDICAL CONDITION)

Diagnosis: _____

ICD-CM Codes: _____

### 2. MEDICAL NUTRITION: SERVICE REQUESTED

❑ Medical Nutrition Therapy (1 hour with dietitian only (97802))
❑ Number of follow-up visits (30 minutes) requested _____: (Each visit ≤ 30 minutes, Individual 97803 or Group 97804)

### LAB RESULTS

Please complete the following OR fax most recent lab results.

A1C:_____ Date Taken: _____ Total Cholesterol: _____ LDL: _____ HDL: _____ Triglyceride: _____ Date Taken:_____

OGTT (for Pregnancy only): 1 Hour: _____ 2 Hour: _____ 3 Hour: _____ Date Taken: _____

## Referring Physician Information

Physician Name (first & last): _____ NPI#: _____ GA License #: _____

Physician Address: _____ Phone #: _____ Fax #: _____

**I hereby certify that the services indicated in the above order form are medically necessary.**

**Physician Signature:** _____ **Date:** _____ **Time:** _____