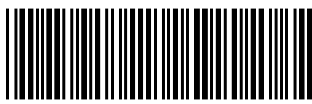
EMORY HEALTHCARE

Tax ID Number: 26-3454941



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: ________________________ (First & Last Name) DOB: ______________ Sex: ❑ M ❑ F SS#: XXX-XX-_____

Patient's Address: ______________________ (Street) ______________ (City) ______ (State) __________ (Zip Code)

Home Phone #: ______________ Mobile Phone #: ______________ Email Address: ______________________

Primary Insurance: ______________________ (Plan & Product) Policy #: ______________ Group #: __________ Phone #: ____________

Secondary Insurance: ______________________ (Plan & Product) Policy #: ______________ Group #: __________ Phone #: ____________

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:** ____________