COOLEY DICKINSON MEDICAL GROUP DIABETES CENTER
22 ATWOOD DR., NORTHAMPTON, MA 01060 PH (413)586-1601 FAX (413)923-9304

Provider Order Sheet

Patient Name:____DOB:___________Date:___________
Home Phone#:___________________________Cell/Work Phone#:______________________________
Insurance & Policy #:____
❑ **PREAUTH FORM SENT TO INSURANCE (to be completed by referring office staff)**

Diabetes Diagnosis: *(check off at least one)*

❑ Type 1
❑ Type 2
❑ IFG/ IGT/ Pre-Diabetes
❑ Type 11/2 or LADA
❑ DM in Pregnancy (**EDC** :____________)
❑ Pre-existing DM
❑ Gestational
❑ OTHER _____________________________

Reason for referral: *(check off at least one in either section or both)*

Problems:
❑ Newly diagnosed with DM
❑ Recurrent hypoglycemia
❑ Recurrent elevated blood glucose levels
❑ Currently on max oral hypoglycemic agent
❑ Other_______________________________

Skills Needed:
❑ Patient needs home blood glucose monitoring
❑ Patient needs to begin insulin therapy: Start orders: Insulin Type:__________ Dose:_______
❑ Carb Counting
❑ Insulin Pump Program
❑ Self management of insulin dosing

Please check services: *(check off at least one)*

❑ **Comprehensive Diabetes Education Program** (meets Medicare standards)
(to include: Initial assessment & goal setting 1hr, Basic Classes 8hrs, MNT & F/U 3hrs)
*__**Special needs for 1:1 sessions due to impairments of**__: ☐ Vision ☐ Hearing ☐ Cognitive
❑ Language, spoken ________________ ❑ Other ______________________________

❑ **Other Education Needs:**
❑ CDE/Diabetes Educator ❑ RD/Nutrition

❑ **Diabetes medication consultation MD/NP**
❑ **Diabetes medication management MD/NP**

__Is patient cleared for exercise__? ❑Yes ❑ No Modification if needed: __________________________
____

This American Diabetes Association Recognized Diabetes Education Program is integral to the care of my patient.
Provider signature:_______________________________________**Date:**______________
Referred by (Print):____________________ _________________**Phone #**____________

Complete form and FAX to 413-923-9304
Order sheet must be at our office before the patient's appointment
Please attach a copy of recent medications and labs (A1c, BMP & lipids, Ultrasound for Pregnant)