DIABETES EDUCATION ORDER FORM
Fax to Diabetes Program: (510) 739-0687

Date:_____

1PO

PATIENT INFORMATION

Last name:_____ First: _____
Date of birth: _____SSN: _____ Home phone: _____
Address: _____ Cell phone:_____ Work: _____
City: _____ Zip:_____ Primary Language:_____

DIAGNOSIS *(check all that apply)*

☑	ICD-10	Type of diabetes:
	E11.9	Type 2 without complications
	E11.65	Type 2 with hyperglycemia
	E10.9	Type 1
	O24.419	Gestational Diabetes (GDM)
	O24.111	Pregnancy (with type 1 or 2)
		Other:
	I10	Hypertension
	E78.5	Hyperlipidemia
Other ICD-10:		

☑	ICD-10	Other:
	R80.9	Microalbuminuria
	N28.9	Renal Disease (non-dialysis)
	H35.00	Retinopathy
	K31.84	Gastroparesis
	G60.9	Peripheral Neuropathy
	I25.9	Chronic Ischemic Heart Disease
	I63.9	CVA
	E10.10	DKA: Diabetic Ketoacidosis Type 1
	E11.69	DKA: Diabetic Ketoacidosis Type 2

DIABETES SELF-MANAGEMENT TRAINING* (select)

☐ Sweet Success Program for Gestational Diabetes (GDM)
Oral Glucose Tolerance date_____, results (mg/dl): fasting____; 1 hour____; 2 hour____; 3 hour____
If glucose patterns above target/high risk range, refer to first available endocrinologist or:_____

☐ Comprehensive Diabetes Self-Management Education and Support *(DSMT)*
- ☐ **Initial** DSMT **(10 hours) OR**
- ☐ **Follow-Up** DSMT (after initial 10 hours DSMT completed) (2 hours)

☐ Individual Diabetes Counseling* *(One-to-one education when group classes are not appropriate)*
***Must identify special needs**:*
☐ Language ☐ Vision ☐ Hearing ☐ Physical ☐ Impaired Mobility ☐ Schedule
☐ Impaired mental status/cognition ☐ Learning disability or Other: _____

☐ Specific Topics if needs vary from above: _____
_____

☐ Insulin Pump Training

DIABETES MEDICAL NUTRITION THERAPY (MNT) (*Diet Prescription on reverse)

☐ **Initial** MNT (3 hours/year) ☐ **Follow-up** MNT (2 hours/year)
*Elements required by the Payor: Order, Diagnosis, Diet Prescription, Identify Special Needs

ATTACH COPIES OF RECENT LABS: glucose, A1C, Chem Panel, and lipids if available.
Perform point of care A1C and capillary glucose as needed

PHYSICIAN NAME: _____ **SIGNATURE:**_____
Address: _____ City: _____ Zip: _____
Phone: _____ Fax: _____ UPIN # _____

11482 ODE 1594 (6/17/20) INTRANET

Washington Hospital Healthcare System
2000 Mowry Avenue, Fremont, California 94538-1716 • (510) 797-1111

DIABETES SERVICES REFERRAL
1900 Mowry Ave, Suite 305 Fremont, CA 94538
Telephone 510-818-6556

PATIENT LABEL

MEDICAL NUTRITION THERAPY DIET PRESCRIPTION

- **Main clinical objective:** _____

Medical Nutrition Therapy* (requires diet prescription):

Check	Therapeutic Diet
☐	Consistent Carbohydrate (CHO) grams per meal per MD _____ or RD (circle)
☐	Insulin: CHO ratio per MD _____ or RD (circle)
☐	Calories for weight reduction per MD _____ or RD (circle)
☐	Low Sodium (check): 2 gram_____ 3 gram_____ other _____
☐	Renal: Na+ (check) 2_____or 3_____ gram / K+ 2_____or 3_____gram other _____ Phos 1200 mg or other _____ Protein controlled per MD _____grams/day or RD (circle)
☐	Low cholesterol
☐	Gluten Free
☐	High Fiber
☐	Fiber Restricted
☐	Other:

EXERCISE PRESCRIPTION

☐ Cleared for exercise, OR

☐ Describe exercise restrictions:_____

_____

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