KentuckyOne Health®

PHYSICIAN ORDER
Education Referral Form for:
GESTATIONAL DIABETES, DIABETES IN PREGNANCY, PREGNANCY NUTRITION COUNSELING, PCOS

LEXINGTON AREA MAIN #'s: 859.313.2393/2595 FAX: 859.313.4390/3347
LOUISVILLE AREA MAIN #'s: 502.587.4465/4576 FAX: 502.560.8419

Berea ONLY: 859.313.4447 Fax: 859.313.3145
SJMS ONLY: 859.497.5833 Fax: 859.497.5839
SJL ONLY: 606.330.6868 Fax: 606.330.6026

LOCATION: ❑ **SJH** ❑ **SJE** ❑ **SJJ** ❑ **SJB** ❑ **SJMS** ❑ **SJL** ❑ **SMEH** ❑ **JH** ❑ **MCJNE** ❑ **JHE** ❑ **JH Shelbyville**

Im referring: _____ (*Pt Name*) Daytime Phone #: _____
for medically necessary outpatient self-management training.
Insurance/Health Plan: _____ Evening Phone #: _____
Insur. ID #: _____ Authorization #: _____ Home town: _____
Date of Birth: _____ S.S.#: _____ Height: _____ Weight: _____

Note to Physician: The following areas (*WRITTEN DIAGNOSIS, MEDICAL CONDITIONS, COMPLICATIONS AND PLAN OF CARE)* are ***required*** for diabetes outpatient reimbursement by various regulatory agencies, payers, and/or insurance companies. *Please pay special attention to these sections.*

1. **DIAGNOSIS:**
   - ❑ **Gestational Diabetes, Diet Controlled** **Code: 024.410**
   - ❑ **Gestational Diabetes, Insulin Controlled** **Code: 024.414**
   - ❑ **Pre-Existing Diabetes Mellitus, Type 1, in pregnancy** **Code: 024.01**
   - ❑ **Pre-Existing Diabetes Mellitus, Type 2, in pregnancy** **Code: 024.11**
   - ❑ **Other:** _____ **Code:** _____

2. **MEDICAL STATUS:** Wks Gestation: _____ Complications: _____
   EDC Date: _____ _____

3. **EDUCATIONAL PLAN -** ***Please check desired educational components***
   - ❑ **Gestational Diabetes Education Program includes:** *overview, assessment, nutrition, exercise, behavior change, monitoring, BG management, future risk of DM, post-partum follow-up.*
     Dietitian to determine nutrition plan unless specified: _____ ❑ Calorie Level: _____
   - ❑ **Insulin Administration:** *Type:* _____ *Dosage:* _____ *Time:* _____
     Type: _____ *Dosage:* _____ *Time:* _____
   - ❑ **Insulin Pump Therapy:** _____ *Rates:* _____
   - ❑ **Nutrition Counseling - Non DM** *Primary Concern:* _____

4. **METABOLIC MANAGEMENT PLAN**
   Testing Frequency Desired: ❑ Fasting ❑ Before meals ❑ 1 hr after meals ❑ 2 hr after meals ❑ _____
   Desired Blood Glucose Range: ***DNC will instruct patient to follow ACOG recommended goals unless physician specifies otherwise.***

ACOG Recommendations	
Fasting	**< 95 mg/dl**
1 hr after meals	**< 130-140 mg/dl**
2 hr after meals	**< 120 mg/dl**

Other	
Fasting:	_____
Before Meals:	_____
1 hr after meals:	_____
2 hr after meals:	_____
2 am - 6 am:	_____

5. **CURRENT MEDICATIONS:** _____
   ☑ **In case of hypoglycemia, follow outpatient hypoglycemia protocol.**
   Recent Laboratory Results: ***** Please send relevant lab reports including OGTT, HbA1c, if available.**

PHYSICIAN SIGNATURE: _____ **DATE:** _____ **PHONE:** _____
PRINT PHYSICIAN NAME: _____ FAX: _____

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PATIENT IDENTIFICATION