

PHYSICIAN REQUEST FOR SERVICES

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Male Female

Address: _____

Home Phone: _____ Day-time Phone: _____

Parent/Guardian Name for Minor Patients: _____

CONSULT REQUESTED

- | | |
|---|--|
| <input type="checkbox"/> Consult Endocrinologist for Endocrine Problem: _____

<input type="checkbox"/> Diabetes Team Management (Endocrinologist, DSMT and MNT)

<input type="checkbox"/> Diabetes Self Management Training (DSMT) (Includes Nurse and Dietitian)

<input type="checkbox"/> Diabetes Medical Nutrition Therapy (MNT Medicare)

<input type="checkbox"/> Gestational Diabetes Education | <input type="checkbox"/> Start Insuling and DSMT Insulin Orders: _____

<input type="checkbox"/> Physician Approval for CDE to Titrate Insulin/Diabetes Medications

<input type="checkbox"/> Continuous Glucose Monitor Procedure

<input type="checkbox"/> Pre-Diabetes Class (\$20 Fee for Service - Cannot be Billed to Insurance) |
|---|--|

REASON FOR CONSULT

- | | |
|---|--|
| <input type="checkbox"/> Type 1 • Uncontrolled 250.03
<input type="checkbox"/> Type 2 • Uncontrolled 250.02
<input type="checkbox"/> Type 1 • Controlled 250.01
<input type="checkbox"/> Type 2 • Controlled 250.00
<input type="checkbox"/> DKA 250.11
<input type="checkbox"/> Other (Please Specify): _____ | <input type="checkbox"/> Gestational 648.83
<input type="checkbox"/> Diabetes in Pregnancy 648.03
<input type="checkbox"/> Pre-Diabetes 790.2
<input type="checkbox"/> Dysmetabolic Syndrome 277.7
<input type="checkbox"/> Hypoglycemia 251.2 |
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LABORATORY RESULTS

In order to efficiently meet the needs of your patients, the following labs are requested prior to the visit. Results should preferably be no older than 3 months. Lab copies may be faxed with this Physician Request for Services form.

Diabetes Patients - A1c, Lipid Profile and Urine Microalbumin

GDM Patients - 1 Hour or 3 Hour GTT

Thyroid Patients - Thyriod Profile and Copies of Scans, etc.

Other Endocrine Patients - All Relevant Labs

- Labs Attached Labs May be Found on Meditech Tests Not on File. Will Order.

PHYSICIAN INFORMATION

Physician Signature: _____ Physician Name (Please Print): _____

Address: _____

Phone: _____ Fax: _____