

Diabetes and Endocrine Center Physician Request for Services Form

(To be completed by referring health care provider)

Referring Physician _____

Patient's Name _____

Address _____

Home phone _____ Work Phone _____ Cell Phone _____

- **Insurance referrals and lab copies** should be available before appointments are scheduled for your patients. Please fax this completed Physician Request for Services Form and labs to: **443-643-3204**
- If this patient has **Medicare**, they must meet the Medicare eligibility criteria for diabetes education. Please contact us for Medicare form.

Please schedule an appointment for: (Check one)

- Diabetes Team Management (Endocrinologist, RN/CDE, RD/CDE)
- Patient Education Only (self-management skills and medical nutrition therapy RN/CDE & RD/CDE)
- Consult by Endocrinologist for Endocrine Problem _____

Reason for referral (Check one)

Required for insurance purposes for all diabetes education referrals

- New Onset Diabetes Insulin Pump
- Uncontrolled Diabetes Other _____

Diagnosis (Check one)

Required for insurance purposes for all diabetes education referrals.

- Type 1 Diabetes Gestational Diabetes
- Type 2 Diabetes Diabetes, type unclear

If pregnant, please provide EDC (due date): _____

Laboratory Findings

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 preferred and may be faxed with this Physician Request for Services Form.

- **Diabetes patients** - A1c, Lipid Profile, and Urine Microalbumin
 Labs attached Labs may be found in Meditech
- **GDM patients** - 1 hour or 3 hour GTT
- **Thyroid patients** – Thyroid profile and copies of scans etc.
- **Other endocrine patients** – All relevant labs

I do not have these tests on file, please order them.

Lab Order: Please perform the following tests: **Copy of Report to the Diabetes and Endocrine Center and PCP**

Please check: A1c Lipid profile Urine microalbumin Creatinine ratio

Physician Signature _____ Date _____

Physician Name _____ Phone _____ Fax _____ E-mail _____