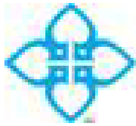

Diabetes Education Center
2615 Enterprise Blvd. Suite B, Lake Charles, LA 70601
PH: (337) 494-6425

PHYSICIAN ORDERS / REFERRAL TO
DIABETES OUT-PATIENT EDUCATION CENTER

FAX TO: (337) 430-6959

Please schedule the following patient for medically necessary Outpatient Diabetes Education:

Patient: ____________________________ Date of Birth: ___________ Age: _____

Address: __________________________ Phone: (H) __________ (W) __________

City: ___________________________ State: _____ Zip Code: __________

Insurance: ________________________ **Referral Date Range: 6 Months**

Physician Diagnosis (Required): Please check all that apply.

___ E11.65 T2DM with hyperglycemia
___ E11.9 T2DM without complications
___O24.419 GDM in pregnancy
____E10.65 T1DM with hyperglycemia
____E10.9 T1DM without complications
____OTHER: Please List Diagnosis Code(s) ______________

****Please attach most recent lab results, medication list, and demographic sheet. ****

Indicate one or more reasons for referral:

___Recurrent elevated blood glucose levels ___Change in DM Treatment Regimen

___Recurrent hypoglycemia ___High risk due to DM complications/co-morbid conditions:

___Retinopathy ___Neuropathy ___Nephropathy ___Gastroparesis ___Hyperlipidemia

___Hypertension ____Cardiovascular disease ____Other ______________________

Indicate any existing barriers regarding customized education:

___Impaired mobility ___Impaired vision ___Impaired hearing ___Impaired mental status/cognition

___Impaired dexterity ___Language barrier ___Eating disorder

___Learning disability (please specify) ________________________________

___Other (Please specify) ____

*****PLAN OF CARE: *****

☐ Comprehensive Self-Management Skills (group) to include Basic Nutrition Management and self blood glucose monitoring.

☐ Comprehensive Self-Management Skills (individual) to include Basic Nutrition Management and self blood glucose monitoring.

☐ Management of Diabetes during Pregnancy/Gestational Diabetes

☐ Insulin Instruction* ____________________ Insulin Pump Instruction* ____________________
*Please attach specific insulin orders

☐ Other Orders: ____

_________________________ _________________________
Physician Signature **Date of Order**

_________________________ _________________________
Print Physician's Name **Phone Number/Fax Number**