Diabetes and Endocrine Center
A CIRCLE HEALTH MEMBER
Complete connected care℠

Diabetes and Endocrine Center
Order Form
FAX TO: 978 323-0362

PATIENT LABEL HERE

PATIENT INFORMATION:

Name: _____ **DOB:** _____/_____/_____ **Gender:** □ **M** □ **F**

Address: _____ **City** _____ **State** _____ **Zip** _____

Patient Telephone: _____ **Interpreter?** □ **No** □ **Yes: Language:** _____ **Office Contact:** _____

PCP Name: _____ **PCP Phone:** _____ **PCP Fax Number:** _____

Primary Insurance: _____ **Secondary Insurance:** _____

STEP 1:

***PREGNANCY: Y / N**

Diabetes Diagnosis: (Check one)

□ Type 1-uncontrolled □ Type 1-controlled
□ Type 2-uncontrolled □ Type 2-controlled
□ Impaired Glucose Tol. □ Impaired Fasting Glucose
□ Pre-diabetes □ New Onset Diabetes
□ Gestational □ Type 2 with pregnancy

Other Endocrine DX: (Please Specify)

□ **Rapidly Enlarging Neck Mass:** ☐ **Yes /** ☐ **No**
□ **Other endocrine disorder:**

_____

STEP 2:

Last A1c_____ **Date:**_____

□ ***Last OV Note w/ Med list*** □ ***Latest Lab Results***

□ Insurance Referral Required ☐ Yes/ ☐ No
Generated? ☐ Yes/ ☐ No

STEP 3:

Complications/Cormorbidities: (Check all that apply)

□ Hypertension □ Dyslipidemia □ CVA
□ CKD Stage: _____ □ Retinopathy □ CAD
□ Anxiety/Depression □ Obesity □ PVD
□ Neuropathy □ Nephropathy
□ Non-healing wound / ulcer □ Other_____

STEP 4: (Check all that apply)

Services Requested:

□ **Evaluation/Management w/ Provider**

☐ No Preference
☐ Dr. Ariza ☐ Dr. Matthew ☐ Dr. Zwerling
☐ Dr. Staii ☐ NP, Methratta ☐ NP, Pentedemos

□ **Medical Nutrition Therapy (MNT)** ***(Dietician only)***

□ Initial (3 hours)
□ Annual follow-up (2 hours)
□ Additional hours_____

□ **Evaluation/Education w/ Diabetes Educator**

***Content:** Define Diabetes. Mediciations, Preventive Care, Preconception/pregnancy, Hyper/Hypoglycemia; Psychosocial, Goal setting/Problem solving, Self Monitoring, Exercise, Sick Day Rules

For All Education: Please Choose GROUP or PRIVATE

□ ***GROUP*** - 2 or more individuals
□ Initial (10 hours or ____ hrs. requested)
□ Follow-up (2 hours or ____ hrs. requested)
□ Insulin Initiation □ Insulin titration
□ Additional insulin training: ____ hrs. requested

□ ***PRIVATE*** for those with special requirements only
(Check all that apply) ____ hrs. requested
□ Vision □ Hearing □ Physical □ Language
□ Cognitive Impairment □ Other _____

By signing below, I certify that the above patient is under my care and that Diabetes Self-Management Education and/or Medical Nutrition Therapy is a necessary part of the patient's medical treatment for the medical diagnosis(es) listed.

Referring Physician

Signature: _____ **NPI #:** _____ **Date:** _____

Printed: _____

DEC OFFICE USE ONLY

DEC Appt. Date: _____ Number of Visits Needed: _____

Providers Name: _____ Providers NPI #: _____