THE QUEEN'S MEDICAL CENTER
Queen's Diabetes Education Center
Phone (808) 691-4823 Fax (808) 691-5399

Provider Orders for: DIPP
DIABETES in PREGNANCY PROGRAM

Referring Providers, please complete the following:

Patient's Name:_____ **D.O.B.** _____

Patient's Phone: Home _____ Cell _____ Work _____

Patient requires customized education for the following reasons: (Check all that apply)
❑ Impaired Visual ❑ Impaired Hearing ❑ Impaired mobility/dexterity ❑ Eating Disorder ❑ Language Barriers
❑ Learning Disability ❑ Impaired Mental Status/Cognition ❑ Other: _____

Reason for Referral and Service Requested:
❑ Education of diabetes during pregnancy: **LMP:** _____ **EDC:** _____

❑ Other: _____

ICD 10 Code: DIAGNOSIS

O24.419 ☑ Gestational diabetes mellitus in pregnancy, unspecified control
O24.410 ❑ Gestational diabetes mellitus in pregnancy; diet controlled
O24.414 ❑ Gestational diabetes mellitus in pregnancy; insulin controlled
O24.019 ❑ Pre-existing DM, Type 1, in pregnancy, unspecified trimester
O24.119 ❑ Pre-existing DM, Type 2, in pregnancy, unspecified trimester
O24.919 ❑ Unspecified DM in pregnancy, unspecified trimester
O30.009 ❑ Twin Pregnancy
_____ **❑ Other pertinent dx:** _____

Current Medications: Medication	Dosage
PLEASE FAX CURRENT MEDICATION LIST	

Nutrition: Term weight gain goal:_____lbs. Pre-gravid Weight: _____lbs. Height: _____ ft_____ in

Exercise Recommendation:
❑ No Limitations ❑ Limitations, as follows: _____

Self Monitoring Blood Glucose Goals (SMBG):
❑ Pregnant: ACOG SMBG will be used unless otherwise specified (Plasma: ≤ 95 fasting, < 140 1 hr PP, <120 2 hr PP)
❑ Please indicate patient's goals if not using ACOG values:
Fasting / Pre-prandial: _____mg/dL 2 Hr Post-prandial: _____mg/dL
Bedtime: _____mg/dL Other: _____mg/dL

Please fax completed form to (808) 691-5399 along with the following:
☑ Copy of the latest original lab values
(Original required by Medicare, handwritten lab values are not acceptable by Medicare)
- **OGTT (if GDM)**
- **HbA1c (if Pre-Gestational)**

☑ Copy of Patient's insurance card(s) if available

I certify that the education is medically appropriate and needed for the above patient.

Physician's Name (please print): _____**NPI:** _____

Physician's Signature: _____**Date:** _____

Physician Phone Number: _____ **Physician Fax Number:** _____

A Summary report will be sent for your records. **Thank you for your referral.**

Medicare Determination: Medicare Part B will cover both Diabetes Self Management Training & Medical Nutrition Therapy in initial and subsequent years without decreasing either benefits as long as DSMT and MNT are not provided on the same date of service. Additional MNT hours in the same benefit year will be covered if the treating physician determines there is a CHANGE in medical condition, diagnosis, or treatment regimen that requires a change in MNT and orders the additional hours.

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