Summa Center for Diabetes Care
444 N. Main St.
Akron, OH 44310-3110
Phone: 330-379-5680
Fax: 330-379-5157

Patient Name:______________________________________ DOB_________________

Address:____

City:___________________________________ State:__________ Zip:______________

Home Phone:________________________ Other Phone:_____________________________

Insurance:____

Special needs for individual instruction: ☐ Vision ☐ Hearing ☐ Language
☐ Other (Specify):____

Height:____________ Weight:________ Pre-Pregnancy Weight (if applicable)__________

DIAGNOSIS:

Type 2
☐ controlled 250.00 ☐ uncontrolled 250.02

Type1
☐ controlled 250.01 ☐ uncontrolled 250.03

☐ Gestational 648.83 EDC__________________
☐ Preexisting diabetes in pregnancy 648.03
☐ Impaired Glucose tolerance 790.22
☐ Impaired fasting glucose 790.21
☐ Dysmetabolic syndrome 277.7
☐ Polycystic Ovary Syndrome 256.4
☐ Other:_________________ Code:_________

Recent Labs: (FILL IN OR ATTACH RECENT LABWORK)

Date:_________ HgbA1C:_______; Lipid Panel Date:_________ Total Cholesterol:______ HDL:______ LDL:______ TG:______

EDUCATION NEEDED

Diabetes Self Management Training/Education (DSMT/E)

☐ Comprehensive Diabetes Management Program (up to 10 hours)*
☐ Annual follow-up to Comprehensive Management Program (up to 2 hours)*
☐ Instruct in insulin administration:
(Type, unit and frequency)____
Is the patient new to insulin? ☐ No ☐ Yes Instruct on pen device? ☐ No ☐ Yes
Continue oral agents? ☐ No ☐ Yes (specify agent, dose, and frequency)____________________
☐ Instruct in non-insulin injectable administration: Type_______________ Dose_______________ Frequency______________

Medical Nutrition Therapy (MNT)

☐ Initial Education (up to 3 hours)
☐ Annual follow-up MNT (up to 2 hours)
☐ Additional MNT services in the same calendar year (specify change in medical condition, treatment and/or diagnosis required)
____ DX Code:___________

☐ Medical Nutrition Therapy for conditions other than diabetes: **List diagnosis and attach applicable lab work:**
____ DX Code:___________

I hereby certify that I am managing this beneficiary's diabetes condition and that the above prescribed training is a necessary part of management.

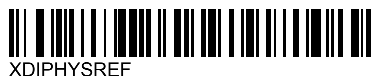
Physician's Signature: (Required)__________________________________ **Date:**______________ **Time:**________

Physician's Name: (Printed)____

Phone:______________________________ **Fax:**________________________________

*Includes the National Clinical Standards and guidelines for: disease process, nutritional management, physical activity, medications for diabetes, self monitoring, preventing acute and chronic complications, goal setting/problem solving and psychosocial adjustment

PATIENT LABEL



90206430 (12/11)

OUTPATIENT DIABETES PHYSICIAN REFERRAL FORM