Ver. 5.0

Diabetic Prescription Referral Form

PATIENT INFORMATION

Name: _____ DOB: _____

Insurance: _____ Insurance ID #: _____

Address: _____ Phone: _____

Caregiver Name (if any): _____ Caregiver Phone: _____

☐ **Enroll patient into Diabetic Education and Nutritional Counseling**

PRESCRIPTION INFORMATION

Testing supplies brand will be dispensed based on patient's insurance formulary. If a specific brand is needed, please contact us.

Glucometer #1: Use as directed to test blood glucose (first fill only unless eligible for resend)

Control solution #1: Use to test the accuracy of the meter up to once weekly

Lancing device #1: Use per package instruction to collect blood sample (see frequency below)

Lancets #quantity as sufficient for 100 days: Use to collect blood sample (see frequency below)

Test strips #quantity as sufficient for 100 days: Use to test blood glucose (see frequency below)

Please select ICD-10 diagnosis:
- ☐ E10.9 (Type 1 DM)
- ☐ E11.9 (Type 2 DM)
- ☐ O24.419 (Gestational DM)
- ☐ R73.03 (Prediabetes)
- ☐ Other: _____

Testing Frequency	Non-insulin Patient	Insulin Patient	
(Please select patient category and one frequency)	☐ Test 1 time daily	☐ Test 1 time daily	☐ Test 3 times daily
	☐ Test 1-2 times daily	☐ Test 1-2 times daily	☐ Test 3-4 times daily
	☐ Test 2 times daily	☐ Test 2 times daily	☐ Test 4 times daily
	☐ *Other Sig: _____	☐ Test 2-3 times daily	☐ *Other Sig: _____

Diabetic Oral Medication: _____ **Diabetic Insulin Medication:** _____

***Medical Justification:** **Required if testing more than 2x/day (non-insulin) or 4x/day (insulin) – only 3 month supply with NO REFILLS**

☐ Gestational Diabetes ☐ Uncontrolled Blood Glucose Levels (must provide 3 glucose readings below 70 mg/dL or above 200 mg/dL)

☐ Insulin Pump Therapy ☐ Sliding Scale Insulin Therapy ☐ Other: _____

Special Instructions: _____ **Refills:** _____
(i.e. Test before each meal)

Refills will be automatically set for 1 year unless otherwise specified

PRESCRIBER INFORMATION

Name: _____

NPI: _____

Phone: _____

Fax: _____

Prescriber Signature: _____

Today's Date: _____

Please advise patient to contact Preveon Health at 909-693-3376.

****Note: In compliance with HIPAA, diabetic supplies can only be mailed AFTER patient has spoken with Preveon Health.****