McLaren
GREATER LANSING

DIABETES EDUCATION PROGRAM - REFERRAL FORM

Phone (517) 975-2270 • Fax (517) 975-2200

Certificate of Medical Necessity

REGISTRATION: (Please print clearly)

Last Name:_____

First Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Home Phone: _____

Work Phone: _____

Social Security # _____

Date of Birth _____/_____/_____ Sex: M / F

Physician:_____

Phone # _____

Fax: _____

Justification for Insurance Reimbursement

Note to Physicians: *The Federal Register states, "Diabetes" is diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria:*

- A fasting blood sugar greater than or equal to 126 mg/dL on two different occasions.
- A 2 hour post-glucose challenge greater than or equal to 200 mg/dL on 2 different occasions.
- Or a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

Diagnosis:

☐ Type 2 ☐ Type 1 ☐ Gestational ☐ Pre-Diabetes

Dx. Date: _____

INSURANCE: (Please print clearly)

Primary Insurance Company Name:

_____

Secondary Insurance Company Name:

_____

CURRENT LABS:

HbA1c: _____ Date:_____

1 Glucose Level:_____ Date:_____

2 Glucose Level:_____ Date:_____

Microalbuminuria Ratio:_____ Date: _____

Lipid Profile Date: _____

Cholesterol:_____ Triglycerides:_____

LDL:_____ HDL:_____

Serum Creatinine:_____ Date:_____

Blood Pressure: _____ Date:_____

Weight:_____ Date:_____

Height: _____ Date:_____

Diabetes Education Ordered ☐

Diabetes Self-Management education will be conducted in a group setting unless the patient is unable to benefit from group because of the following special needs.

☐ Visual/Hearing impairment
☐ Learning Disability
☐ Impaired psychosocial status
☐ Insulin Instruction
☐ Impaired Mental Status
☐ Impaired Mobility
☐ Impaired Dexterity

PHYSICIAN SIGNATURE

X _____ **DATE**: / /

(Must be hand written by the Physician, no co-signing)

Diabetes Program Use only

Referral Date:_____ Class/Appointment Date: _____

Comments: _____

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806-03 (3/13)

640