### Ambulatory Adult Diabetes Care Order

#### PATIENT DEMOGRAPHICS

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone</td>
<td>Other Phone</td>
</tr>
<tr>
<td>Insurance</td>
<td></td>
</tr>
</tbody>
</table>

#### DIAGNOSIS

**New Diagnosis**
- Type 1 [E10.9]
- Type 2 [E11.65]
- Gesta
tional; _______ weeks [O24.419]

**Previous Diagnosis**
- Type 1 uncontrolled [E10.65]
- Type 2 uncontrolled [E11.65]
- Dysmetabolic Syndrome [E88.81]
- Type 1 or 2 and pregnant [O24.319]

#### Current Diabetes Medication/Regimen

#### Laboratory Information

<table>
<thead>
<tr>
<th>Date</th>
<th>Lipid Profile</th>
<th>Total Chol.</th>
<th>LDL:</th>
<th>HDL:</th>
<th>Trig:</th>
</tr>
</thead>
</table>

#### DIABETES EDUCATION NEEDS

**Type of training:**
- Total assessment and education for newly diagnosed patient – initial group education – 10 hours
- Annual follow-up and education for previously diagnosed patient – annual follow-up – 2 hours

**Topics:**
- Comprehensive knowledge assessment & instruction
- Blood glucose meter instruction
- New or Change in order: Type/Dose/Time of day:

**Exercise Plan:**
- No Restrictions
- Exercise with restrictions

**Special Educational Needs Requiring Individual Visit**
- Interpreter: specify
- Vision:
- Cognitive Impairment:
- Low Literacy:
- Hearing impaired:
- Additional insulin training:

**PROVIDER AGREEMENT/INFORMATION**

By signing below, the certified diabetes educator (CDE) at HealthEast/Fairview/University of Minnesota Health (M-Health) may make dose adjustments to currently prescribed diabetes medications and educate on blood glucose goals according to American Diabetes Association Guidelines.

**Referring Provider**
- Phone

**Clinic**
- Phone

**PROVIDER ORDER FOR BLOOD GLUCOSE TESTING SUPPLIES**

<table>
<thead>
<tr>
<th>Meter</th>
<th>Test Strips, # to be dispensed:</th>
<th>Control solution</th>
<th>Lancets</th>
<th>Ketostix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refill(s):</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

**Recommend Testing:**
- 2 times/day
- 3 times/day
- 4 times/day
- Other:

**PROVIDER SIGNATURE**
- Date
- Time
- Print Name
- Phone/Pager