ADDRESSOGRAPH

1500

NORTHSIDE HOSPITAL

AFFIX PATIENT LABELS OVER THIS BOX

BAR CODE MUST FALL BETWEEN THESE LINES

Location:	Appointment No.	Fax No.
❑ **Atlanta** ❑ **Alpharetta** ❑ **Forsyth**	404-851-6023	404-845-5972
❑ **Cherokee**	678-388-6400	678-388-6410

Patient Name: _____ DOB: _____ Gender: ❑ M ❑ F

Address:_____City_____State_____Zip_____

Phone: (H) _____ (W) _____ (C) _____

English Speaking: ❑ Yes ❑ No Language preferred _____

Ordering Physicians Name: _____

Ordering Physicians Phone Number: _____ Ordering Physicians Fax Number:_____

Diagnosis:

❑ Type 1 (E10.9) ❑ Type 2 (E11.9) ❑ Gestational Diabetes (O24.419) ❑ Impaired fasting (R73.01)
❑ Metabolic Syndrome / Insulin Resistance (E88.81) ❑ PCOS (E28.2) ❑ Other, abnormal glucose (R73.09)
❑ Impaired glucose tolerance test- oral (R73.02) ❑ Abnormal Glucose in Pregnancy (O99.810)

Please fax a copy of any pertinent history and the most recent labs along with the referral (i.e. FBS, HbA1c, Triglycerides, Chol, HDL, LDL, Urine Microalbumin)

Check to activate Orders

1. Group Classes (If patient has special needs and requires individualized education, please select the class AND the reason individualized education is required) :

❑ *Type 1 & Type 2 Comprehensive Self-Management Education *(Nutrition education included in class)*
❑ *Gestational Diabetes / Abnormal Glucose in pregnancy Self-Management Education *(Nutrition education included in class)*
❑ *Diabetes Prevention *(Nutrition education included in class)*

***For patients with special needs requiring an individualized education from the above list, please check all that apply (the reason for individualized education must be selected):**

❑ Severe vision impairment ❑ Severe hearing impairment ❑ Language limitation ❑ Physical Limitations
❑ Impaired mental status/cognition ❑ Other _____ (please specify): _____

2. Individual Sessions: (these do not require reason for individualized education)

❑ PCOS
❑ Medical Nutrition Therapy for Diabetes *(this class contains only the nutrition management of diabetes)*
❑ Diabetes Education Refresher **(Nutrition education included in class)*
❑ Insulin Initiation - Insulin Type(s): _____

Insulin/Injectable Regimen: _____ AC Breakfast _____ AC Lunch

_____ AC Supper _____ Bedtime

_____ Verbal or telephone order read back and verification complete
receiver's initials

Ordering Physician Signature: _____ Date: _____ Time: _____