

MOMMY & ME
MATERNITY / INFANT OUTREACH PROGRAM
Outpatient Gestational Diabetes Education Program

TO:

(DO NOT FILL IN)

(DO NOT FILL IN)

I am referring this patient for: Comprehensive Program
 Glucose Meter & Training
 Insulin Start
 Type and dose _____
 Diet instruction follow-up

[Please print]

Patient Name: _____ Auth: _____

Address: _____ Apt: _____ City: _____

ProCare ID# _____ SSN# _____ DOB _____

Home Phone: () _____ Work Phone: () _____

Note: This area must be completed

HgA1C % _____ **Date: _____ Exercise restrictions: __yes __no

If exercise restrictions please specify _____

Diagnosis - -Please check all that apply

- | | |
|---|--|
| <input type="checkbox"/> 250.00 type 2 without complication | <input type="checkbox"/> 250.01 type 1 without complications |
| <input type="checkbox"/> 250.02 uncontrolled type 2 | <input type="checkbox"/> 250.03 uncontrolled type 1 |
| <input type="checkbox"/> 250.4 DM with renal manifestations | <input type="checkbox"/> 272.4 Hyperlipidemia |
| <input type="checkbox"/> 250.5 DM w/ophthalmologic manifest | <input type="checkbox"/> 536.3 Gastroparesis |
| <input type="checkbox"/> 250.6 DM w/neuro manifestations | <input type="checkbox"/> 250.7 DM w/ PVD |
| <input type="checkbox"/> 277.7 Metabolic syndrome X | <input type="checkbox"/> 278.00 Obesity, unspecified |
| <input type="checkbox"/> 401.1 Hypertension, benign | <input type="checkbox"/> 791.0 Proteinuria |

Physician Signature

Physician Name **PLEASE PRINT**

Physician Address

Physician Phone

Fax #

PLEASE FAX COMPLETED FORM / A COPY OF **RECENT LABS AND
CURRENT MEDICATIONS TO: PROCARE HEALTH PLAN**