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# PHYSICIAN ORDER SHEET

## Patient Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

Phone \_\_\_\_\_

Primary Insurance \_\_\_\_\_ ID number \_\_\_\_\_

### MEDICAL NUTRITIONAL THERAPY

#### Diagnosis/Diagnoses:

- Diabetes Mellitus 250.00/250.01
- Non-dialysis CRI/Non-Dialysis ESRD
- (Other) \_\_\_\_\_

#### Order:

- MNT-Diabetes Mellitus, insulin or non-insulin dependent
- MNT, non-dialysis CRI and non-dialysis ESRD

### DIABETES TESTING SUPPLIES

#### Testing Frequency:

- 1/DAY  2/DAY  3/DAY  4/DAY  5/DAY

#### If non-insulin dependent, reason for testing >1/day:

- Widely fluctuating blood sugar
- Ketoacidosis
- Other \_\_\_\_\_

#### Items to be dispensed:

- |                                                             |                                                       |
|-------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Home blood Glucose Monitor (E0607) | <input type="checkbox"/> Lancet Device (A4258)        |
| <input type="checkbox"/> Lancets (A4259)                    | <input type="checkbox"/> Test Strips (A4253)          |
| <input type="checkbox"/> Replacement Battery (A4254)        | <input type="checkbox"/> Calibration Solution (A4256) |

Physician: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Phone: \_\_\_\_\_ UPIN: \_\_\_\_\_ NPI: \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

PLEASE FAX THIS SIGNED ORDER BACK TO 724-933-1916