PHYSICIAN'S ORDER FOR
HOME DIABETES TESTING SUPPLIES

614 E Altamonte Dr
Altamonte Springs, FL 32701
Phone: 407-849-6455
Fax: 407-849-6458

EFFECTIVE DATE: ___/___/______

Patient Information:
Name: ____
Address: ____
City/State/Zip: __________________________________
Phone: (____) ______________ **DOB:** ______________

Physician Information:
Name: ____
Address: ____
City/State/Zip: __________________________________
Phone: (_____) ___________ **Fax:** (____) ____________
NPI: ________________ **License #:** _______________

All Sections must be completed. Please sign and date any changes you make to this information.

DIAGNOSIS INFORMATION **Length of need:** 12 Months unless otherwise specified: ____________

☐ Non-Insulin Dependent 250.00 ☐ Insulin Dependent 250.01 ☐ Gestational Diabetes 648.80 ☐ Other _ _ _. _ _

BLOOD GLUCOSE METER SUPPLIES

☐ Blood Glucose Meter ☐ Test Strips ☐ Lancing Device ☐ Lancets ☐ Glucose Meter Battery ☐ Control Solution

☐ Other ____

Is patient injecting insulin to control their diabetes? Yes _____________ **No** _____________

Patient is being prescribed to test their blood sugar levels at home (X's / day)

☐ 1 x/day – 100 strips, lancets/3 months ☐ 2 x/day – 200 strips, lancets/3 months ☐ 3 x/day – 300 strips, lancets/3 months
☐ 4 x/day – 400 strips, lancets/3 months ☐ 5 x/day – 500 strips, lancets/3 months ☐ 6 x/day – 600 strips, lancets/3 months
☐ 7 x/day – 700 strips, lancets/3 months ☐ 8 x/day – 800 strips, lancets/3 months ☐ 9 x/day – 900 strips, lancets/3 months
☐ Other ______ x/day ________strips/lancets/3 months

FOR HIGH FREQUENCY TRESTING REGIMEN

Medicare requires an explanation for testing more frequently than; **1 x/day non-insulin treated or 3 x/day insulin treated;** therefore, confirm that I have seen this patient within the last six (6) months to evaluate their diabetes control and have noted below the reason(s) for high testing frequency.

I am prescribing the above indicated home blood glucose testing regimen because:

☐ There is a large fluctuation in the level of blood sugar
☐ To control hypoglycemia states after meal
☐ In order to avoid episodes of nighttime hypoglycemia
☐ Patient does not have control of their diet
☐ Other (please explain) ____

Physicians please note: No product authorized herein will be supplied without the consent of the patient.

BY SIGNING BELOW, I AM STATING THAT: I am or was this patient's treating physician during the order period. This order accurately reflects the patient's condition, my prescription for home blood glucose testing, and is substantiated by medical records. The patient or their caregiver is able to follow instructions for controlling diabetes and is able to use the ordered items. **I will maintain an original signed copy of this order in my medical records and make it available to Medicare, their authorized agents or other insurer, if required.**

X ____ ________________________________

Physician Signature *Date*