Physician's Order
Diabetic Supply Referral

AIM PLUS MEDICAL SUPPLIES

Please fax form with physician's signature to: 1-866-496-7054

PATIENT INFORMATION

Name: _____ **Date of Birth:** _____
Primary Phone _____ **Alternate Phone**_____
Address_____ **City/State/Zip**_____
Primary Insurance_____ **ID#**_____
Secondary Insurance_____ **ID#**_____
Contact person if other than patient:_____

REQUIRED INFORMATION FOR ALL PATIENTS

PLEASE COMPLETE THIS SECTION IN FULL

◄► **Date of last office visit**_____

◄► **Type 1— IDDM**
Insulin Dependent
☐ **E10.9 (250.01)**
☐ **E10.65 (250.03)**

☐ **Other**_____ **(specific)**

◄► **Type 2—Choose One**
Pills, Diet, and/or Insulin Treated
☐ **E11.9 (250.00)**
☐ **E11.65 (250.02)**

☐ **Other**_____ **(specific)**

◄► **Duration of need: 12 months unless otherwise noted** _____

A1C if on pump: _____

◄► **Testing frequency:** _____

◄► **Using insulin to control?** ☐ **Yes** ☐ **No**

◄► **Number of injections a day?** _____

Glucose Test Strips_____**X**___
(Product Name)_____
Lancets_____**X**_____
(Product Name)_____
Lancing Device_____**PRN**____
Ketostix_____**X**_____
Alcohol Swabs_____**X**_____
Other:_____

Meter Battery_____**PRN**___
Control Solution_____**PRN**_
Meter_____**PRN**_____
Other:_____
_____

Infusion sets_____**X**_____
Reservoirs_____**X**_____
Transparent Tape_____**X**____
Prep Wipes_____**X**_____
Adh. Remover_____**X**_____

My signature below denotes to the best of my knowledge the patient/caregiver is able to follow instructions for controlling diabetes and is able to use the ordered items which are designed for home use. The patient/caregiver has successfully completed training or is scheduled to begin training in the use of supplies or equipment ordered. I am a physician who manages patients with diabetes and/or insulin pump therapy and who works closely with a team including nurses, diabetes instructors and dieticians who are knowledgeable in the use of subcutaneous insulin infusion therapy. **Physician Staff Contact**_____

►**Physician Name (print)** _____**NPI**_____

►**Physician Signature**_____►**Date**_____

►**Physician Phone #**_____ **Fax #**_____