Hart Medical Equipment

Please fax to: (989) 895-4519

Questions call: (810) 866-9564

Continuous Glucose Monitor & Insulin Pump Rx

Order Date:_____ Patient Name:_____

For office use only
Account #:_____

Phone:_____ D.O.B.:_____ Sex: M / F Height:_____ Weight:_____ Insurance #: _____

Address:_____ City:_____ State:_____ Zip: _____

Currently using insulin pump? ☐ Yes ☐ No Currently using CGM? ☐ Yes ☐ No Current glucometer: _____

Number of insulin injections/day: _____ Blood sugar testing times/day: _____ Fasting blood sugar: _____ mg/dl Date: _____

Fluctuating of blood glucose levels: Low:_____ mg/dl and High:_____ mg/dl HbA1c: _____ Date: _____

Endocrinology Service:_____ Phone:_____ Fax:_____

Supporting Clinical Information:

☐A. History of hypoglycemia unawareness

☐B. History of severe glycemic excursions

☐C. History of nocturnal hypoglycemia

☐D. Recurring episodes of severe hypoglycemia

☐E. Evidence of unexplained severe hypoglycemia episodes requiring external assistance for recovery

☐F. Patient has been hospitalized or has required paramedical treatment for low blood sugar

☐G. Dawn phenomenon where fasting blood glucose level often exceeds 200 mg/dl

☐H. Day-to-day variations in schedule, mealtimes and/or activity level, which complicates the degree of control required to self-manage hyperglycemia with multiple insulin injections

☐I. History of suboptimal glycemic control before or during pregnancy

☐J. Poor glycemic control as evidenced by 72 hour CGMS sensing trial

☐K. Multiple alterations in self-monitoring and insulin administration regimens to optimize care

☐L. Patient has completed comprehensive diabetes education

☐M. Patient has demonstrated ability to self-monitor blood glucose levels as recommended by physician

☐N. Patient is motivated to achieve and maintain improved glycemic control

Prescription Information

Duration of Need: ☐12 months or ☐Other:_____ Diagnosis: _____

☐Gestational Diabetes using insulin ☐Gestational Diabetes not using insulin Due Date:_____ ☐Other: _____

Current complications / comorbidities: _____

Insulin Pump: ☐Insulin Pump ☐Pump Reservoirs: 10-20 sets/month ***or*** 30-60/ 3 months ☐Infusion sets/kits: 10-20 sets/month ***or*** 30-60/ 3 months

☐Omnipods: 10-20 sets/month **or** 30-60/ 3 months

Continuous Glucose Monitoring (CGM): ☐CGM Transmitter 2/year ☐CGM Receiver 1/year

☐CGM Sensor: ☐Dexcom: 3/month ***or*** 9 sensors/3 months | ☐Libre: 2/month ***or*** 6 sensors/3 months | ☐Medronic: 4/month ***or*** 12 sensors/3 months

Glucometer: Please check testing frequency and number of strips/lancets prescribed for this patient per day:

☐Testing 4x = 150/mo ☐Testing 5x = 150/mo ☐Testing 6x = 200/mo ☐Other Testing:_____

☐Blood Glucose Monitor 1/5 yrs ☐Test Strips per above ☐Lancets per above ☐Lancing Device 1/6 mos ☐Control Solution 1/3 mos

Reason for testing frequency: ☐Fluctuating blood sugar ☐Control hypoglycemic episodes ☐Hyperglycemia ☐Uncontrolled

☐Pregnancy ☐Other: _____

Physician Signature

Physician Name: _____ NPI:_____

Phone:_____ Address:_____

Physician Signature:_____ Date:_____

All information documented on this form must also be documented in the patient's medical record.