DOUBEK medical supply

TF: 800.368.2358
F: 708.293.1144
doubekmedical.com

Referral Name: _____

Referral #: _____

Fax to (708) 293-1144

Insulin Pump Referral Form

PATIENT INFORMATION

Order Date: _____ ☐ Female ☐ Male

Patient Name: _____ Date of Birth: _____

Address: _____

Email Address: _____ Phone #: _____

PATIENT INSURANCE INFORMATION

Insurance Type: ☐ Medicare ☐ Medicaid ☐ Private Insurance _____

Insurance ID #: _____ Group # _____

It is not necessary to fill it out this section, if the order is accompanied by a copy of the patient's insurance card.

ORDER:

Type of Pump: ☐ Accu-chek Spirit Combo ☐ Animas OneTouch: Ping/Vibe ☐ Omnipod ☐ Tandem: t:slim/t:flex/t:slim G4

***Model #:** _____ _____ _____ _____

Type of Infusion Set: _____

Tubing Length: ☐ 23 in. ☐ 31 in. ☐ 43 in. **Cannula Length:** ☐ 6mm ☐ 8mm ☐ 9mm ☐ 10mm ☐ 13mm ☐ 17mm

Cartridges/Reservoirs: ☐ 1.8 mL ☐ 2.0 mL ☐ 3.0 mL ☐ 3.15 mL ☐ 4.8 mL

Other Pump Supplies: ☐ Pods ☐ Opsite Adhesive IV Site Dressing ☐ IV Prep Wipes ☐ Other: _____

Dexcom CGM Supplies: ☐ Receiver: G4/G5 (with Share) ☐ Transmitter: G4/G5 (with Share) ☐ Sensors

Meter Info: ☐ Needs ☐ **Owns** _____ Meter

Diabetes Testing Supplies: ☐ Strips ☐ Lancets ☐ Alcohol Wipes ☐ Lancet Device ☐ Control Solution ☐ Ketone Strips

Duration of Need 99 (Lifetime) unless otherwise noted: _____

Diagnosis: [☐ Type 2 (Adult Onset) ☐ Type 1 (Juvenile)] **Treated by:** [☐ Insulin/Pump ☐ Pills ☐ Diet ☐ Exercise]

Tests per Day: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ _____ (Other)

Treating Physician's Name: _____ Phone #: _____

Address: _____

My signature below confirms that I am currently treating the patient for their diabetic condition and am prescribing the above diabetic supplies which are designed for home use, and I have crossed out any items I am not prescribing. To the best of my knowledge, the patient/caregiver has been/will be trained on the use of the monitor and supplies and is able to use this equipment to help control the patient's diabetes. Furthermore the prescribed testing frequency is substantiated in the patient's medical records.

Physician's Signature: **X**_____ Date: _____ NPI: _____

(if possible)

I have reviewed the information above and find it to be accurate. I agree to use these supplies and/or equipment as prescribed by the physician and confirm that I have been/will be or my caregiver has been/will be trained in the use of the supplies and/or equipment listed above. I understand the supplies are prescribed for home therapy and cannot be re-dispensed. I will follow-up with Doubek Medical Supply &/or Pharmacy with any questions or for information on how to obtain supplies by calling them at 708-293-1122. I authorize payment of medical benefits be made directly to Doubek Medical Supply &/or Pharmacy. I understand co-pays and/or deductibles may apply. I authorize release of any medical or other information necessary to process claims.

Physician's Signature: **X**_____ Date: _____ NPI: _____

(If signed by someone other than Patient) – Reason: _____ *Relation:* _____