Continuous Glucose Monitor (CGM) Order Form

PATIENT

Name_____

Address_____

_____

Phone (_____)_____

Diagnosis:_____

SUPPLIER

American Wound Care

1720 Kaliste Saloom A6 – Lafayette, LA 70508

Phone: (800) 728-2788 / Fax: (866) 991-0388

Email: Orders@AmericanWoundRx.com

DOB _____/_____/_____ Sex_____

****If face sheet is included, see attached****

****

DIAGNOSIS:

_____ Patient has Diabetes Mellitus; and

_____ Patient is insulin treated (E11.65); **or**

_____ Patient is non-insulin treated (E11.649) with Hypoglycemic events (<54mg/dL)

Date of Last Patient Visit: _____

CGM & SUPPLIES:

____ Sensors, skin prep supplies for 90 days and refills for one year

____ CGM Reader if patient does not have one. Freesyle Libre 3 or Dexcom G7

Frequency of sensor changes per manufacturer's guidelines, unless otherwise noted.

Comments:_____

PRESCRIBER ATTESTATION

I confirm that the patient has diabetes, periodically being treated by me and I have treated the patient within the prior 6 months either in-person or via telehealth. All the information contained on this Physician Order accurately reflects the patient's diabetic condition and the treatment regimen that I have prescribed. The patient/caregiver has for will be trained for proper use of the ordered items.

_____ _____

Printed Name Prescriber Signature Date

_____ NPI#:_____

Street Phone (____)_____-_____

_____ Fax (____)_____-_____

City

Fax or Email completed form and demographic sheet to:
Fax: 866.991.0388
Email: Orders@AmericanWoundRx.com / eRx via Parachute