

Toll free: 877-671-8299
Fax: 818-566-7559



**Diabetic Supply
Order Form**

* Free Delivery
* Free Alcohol Pads

Name: _____ Tel#: (____) _____

D.O.B: _____ Sex: F _____ M _____ SS#: _____

Address: _____

City: _____ State: **CA** Zip Code: _____

Medicare#: _____ Medi-Cal#: _____ Other: _____

Required Duration: _____ 6 Month _____ 12 Month

By signing this document as the treating physician of the above mentioned patient, I certify that either the patient, a member of the immediate family, home health nurse, or the household is capable of being trained to use the home blood glucose monitor.

- Glucose Monitor
- Glucose Test Strips: ()50 ()100 _____
- Lancets: 100
- Alcohol Pads 1 box
- DX: Type 1 Diabetes – 250.01 (Insulin Dependent)
- DX: Type 2 Diabetes – 250.00 ()Non Insulin ()Insulin Dependent

SID _____ QD _____ BID _____ TID _____ QID _____ UD _____

Cal Lic# _____ UPIN# _____ DEA# _____

Doctors Name: _____

Address: _____

City: _____ State: **CA** Zip Code: _____

Tel#: (____) _____ Fax#: (____) _____

Signature: _____ Date: _____