EVERSENSE 365® CGM
Patient Referral Form

Advancing Diabetes Management Through Innovative Care

eversense@sageinfusion.com | www.sageinfusion.com/SubmitOrder

PATIENT INFORMATION

Patient Name: _____ **DOB**: _____ **Gender:** ☐ M ☐ F

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Phone: _____ **Email:** _____ **Ht:** _____ **Wt:** _____

Please Attach: ☐ Insurance cards ☐ History & Physical ☐ Most recent labs ☐ Medication list

☐ **NKDA** ☐ **Allergies:** _____

PRESCRIBER INFORMATION

Ordering Provider Name: _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____

Practice Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

REQUIRED INFORMATION

☐ **Clinical Notes:** Two or more recent clinical notes supporting the primary diagnosis

Diabetes: ☐ Type 1 ☐ Type 2

Insulin Usage:

Insulin Type: _____ # of Units: _____ Frequency: _____

Insulin Pump: ☐ Yes ☐ No

If Yes, Brand: _____

Use of Continuous Blood Glucose Monitor in the past? ☐ Yes ☐ No

If Yes, Brand: _____

Please Note:
Eligibility for Eversense® 365 implantation is subject to applicable program requirements and clinical criteria.

Signature: _____ **Date:** _____

Fax Number

☐ **Gainesville (352) 450-8886** ☐ **St. Petersburg (727) 977-8836** ☐ **Lakeland (863) 777-2528**