

DIABETES SELF-MANAGEMENT EDUCATION/TRAINING AND MEDICAL NUTRITION THERAPY REFERRAL FORM


Patient Information

Patient's Legal Last Name:		First Name:	Middle:
Date of Birth:	Home Phone:	Other Phone:	
____/____/____	(____) - ____ - ____	(____) - ____ - ____	
Address:		City:	State: Zip Code:
Insurance:		Prior Authorization #:	

Diabetes Diagnosis

- Type 1 Diabetes
- Type 2 Diabetes
- Gestational Diabetes
- Pre-existing Type 1 Diabetes in pregnancy
- Pre-existing Type 2 Diabetes in pregnancy
- Pre-diabetes

ICD-10

- E10.9
- E11.9
- O24.419
- O24.019
- O24.119
- R73.03

Diabetes Lab Results:

- FBS: _____ mg/dl _____ Date
- HgbA1C: _____ % _____ Date
- See Power Chart**

(fasting blood glucose 100 - 125 or HbA1c 5.7 - 6.4)

Diabetes self-management education/training (DSME/T) and medical nutrition therapy (MNT) are individual and complementary services to improve diabetes care. Both services can be ordered in the same year. Research indicates MNT combined with DSME/T improves outcomes.

Diabetes Self-Management Education/Training (DSME/T)

(Medicare coverage: 10 hours initial and 2 hours each year thereafter)

The patient is to attend the following:

- Initial Diabetes Self-Management Training (10 hours) _____ hours requested
(includes all ten content areas, as appropriate, based on assessment)
- Annual Update (2 hours) _____ hours requested

This patient cannot effectively participate in group instruction because of the following special needs:

- Physical Language limitation
- Learning disability Cognitive impairment
- Hearing / Vision Other: _____

Additional Self-Management Training Request

- Pre-diabetes Group Class
- GDM Class or Pre-existing Diabetes in Pregnancy Class
- Insulin Instruction (1:1) *(complete Insulin Instruction Checklist, form #10934)*
- Pump Assessment/Start-up Pump Upgrade
- Pump w/ Sensor Training Sensor Training
- Professional Continuous Glucose Monitor
- Injection Therapy Education *(GLP / Other: _____)*

Medical Nutritional Therapy (MNT)

- Initial MNT
 - 3 hours _____ hours
- Annual follow-up
 - 2 hours _____ hours
- Additional reinforcement of nutrition in the same calendar year per RD
 - _____ hours requested

Specific Instructions: _____

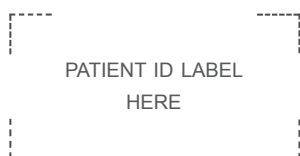
Provider's Signature: _____ Date: _____ Time: _____

Provider's Printed Name: _____ NPI #: _____

Practice Name: _____

Address: _____

Phone Number: _____ Fax Number: _____


MMC Diabetes Education
 Ph: 231-935-8200 F: 231-935-8215

MHC Charlevoix Hospital Diabetes Education
 Ph: 231-547-8737 F: 231-547-8893

MHC Manistee Hospital Diabetes Education
 Ph: 231-398-1840 F: 231-398-1835

POMH Diabetes Education
 Ph: 231-352-2260 F: 231-352-2234

OMH Diabetes Education
 Ph: 989-731-7872 F: 989-731-7837

KMHC Diabetes Education
 Ph: 231-258-3091 F: 231-258-3600