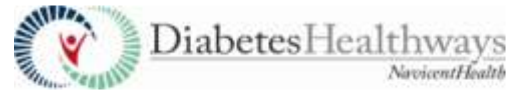
PROVIDER ORDER FORM: Diabetes Self-Management Education/Training & Medical Nutrition Therapy



I, the treating physician or qualified non-physician practitioner, am referring this patient for medically necessary DSME/T and/or MNT.

Please complete this form, sign, and fax to the appropriate location.

☐ **Diabetes Healthways**
Phone: **478-633-1531**
Fax: **478-633-5141**

Patient Information:

Last Name: ____________ Date of Birth: ____________ Home Phone: ____________
First Name: ____________ SSN: ____________ Cell Phone: ____________
Insurance: ____________ Address: ____________

Diagnosis: Please check all applying to this referral.

☐ E11.22:T2DM with diabetic chronic kidney disease
☐ E11.42:T2DM with diabetic polyneuropathy
☐ E11.649:T2DM with hypoglycemia without coma
☐ E11.65:T2DM with hyperglycemia
☐ E11.9:T2DM without complications
☐ Z79.4:Long term/current use of insulin
☐ E10.22:T1DM with diabetic chronic kidney disease
☐ E10.42:T1DM with diabetic polyneuropathy
☐ E10.649:T1DM with hypoglycemia without coma
☐ E10.65:T1DM with hyperglycemia
☐ E10.9:T1DM without complications
☐ Z96.41:Presence of insulin pump
☐ O24.019:Pre-existing DM, T1, pregnancy, unspecified trimester
☐ O24.119:Pre-existing DM, T2, pregnancy, unspecified trimester
☐ O24.410:GDM, pregnancy, diet controlled
☐ O24.414:GDM, pregnancy, insulin controlled
☐ R71.01:Impaired fasting glucose
☐ R73.02:Impaired glucose tolerance (oral)
☐ Other – Include ICD-10 code and description if not listed above:
____
____

Plan of Care: Check desired services.

☐ **Initial Comprehensive DSME/T*:** Includes 9 hours Group and 1 hour 1:1 in a 12-month period unless hours/content otherwise noted in Alternative DSME/T Hours and Content section.

☐ **Refresher/Follow-up DSME/T*:** 2 hours Group or 1:1 (unless hours otherwise noted: ____ hours)

☐ **Prediabetes DSME/T*:** 1 hour Group or 1:1 (Not reimbursed by Medicare)

☐ **Pregnancy DSME/T*:** 4 hours Group and 1 hour 1:1 (Can include education related to preconception, prenatal and/or postpartum)

☐ **Alternative DSME/T hours and Content:** ____ hours, ☐ Disease Process and Treatment, ☐ Coping, ☐ Nutritional Management, ☐ Physical Activity, ☐ Monitoring, ☐ Acute Complication Risk Reduction, ☐ Chronic Complication Risk Reduction, ☐ Medication, ☐ Behavior Change/Goal Setting

☐ **Insulin Training:** 1 hour Group or 1:1
Educator may adjust insulin per protocol:
☐ Yes ☐ No Insulin Prescription: ________
____
____

☐ **New to Insulin Pump Therapy Training:** (Includes assessment, pump start, insulin adjustment and follow-up)
Insulin Pump Prescription: ______________
____

☐ **Insulin Pump Therapy Upgrade Training:**
Insulin Pump Prescription: ______________
____

☐ **Carbohydrate Counting:**
☐ Consistent Carbs
☐ Intensive Insulin Adjustment
Insulin Type________________
Insulin:Carb ratio______________
Correction formula______________

☐ **Initial MNT:** 3 hours (unless hours otherwise noted: ______ hours). Visit Reason:
____

☐ **Follow-Up MNT:** 2 hours (unless hours otherwise noted: ______ hours). Visit Reason:
____
____

☐ **Other:** __________________________
____

***Content delivered per assessment:**
Disease Process and Treatment, Coping, Nutritional Management, Physical Activity, Monitoring, Acute Complication Risk Reduction, Chronic Complication Risk Reduction, Medication, Behavior Change/Goal Setting

Special Needs: Patient has special needs and requires individual (1:1) DSME/T instead of group DSME/T. Check all that apply.

☐ Cognitive impairment ☐ Physical impairment ☐ Language limitation ☐ Interpreter needed
☐ Hearing impairment ☐ Sight impairment ☐ Vision impairment ☐ Other: ________________

Lab Results/Anthropometrics: Please FAX labs (A1C, Lipids, BP, UACR, GFR) ☐ Labs in :

	Result		Date		Result		Date		Result		Date
Height:		inches		Chol:		mg/dL		Trig:			
Weight:		kg		HDL:		mg/dL		Other:			
HbA1c:		%		LDL:		mg/dL		GFR:		mL/min/1.73m^2	

Provider Name (Print): ____________ **Provider Signature:** ____________
Provider NPI: ____________ **Provider Phone:** ____________ **Date:** ____________