

Diabetes Services Order Form (DSMT and MNT Services)

*Indicates required information

Fax to 253.2370

PATIENT INFORMATION

Patient's Last Name _____ First Name _____ Middle _____

Date of Birth ____/____/____ Medicare HICN # _____ Race _____ Gender _____ Male _____ Female

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Other Contact Phone _____

Diabetes self-management training (DSMT) and medical nutrition therapy (MNT) are individual and complementary services to improve diabetes care. For Medicare beneficiaries, both services can be ordered in the same year. Research indicates MNT combined with DSMT improves outcomes.

DIABETES SELF-MANAGEMENT TRAINING (DSMT)

***10 hours initial DSMT in 12-month period, plus 2 hours follow-up DSMT annually**

**Check type of training services and number of hours requested:*

- X Initial group DSMT: X 10 hours or ____ no. hrs. requested
X Follow-up DSMT: X 2 hours or ____ no. hrs. requested
 Additional insulin training: ____ no. hrs. requested

*** Patients with special needs requiring individual DSMT**

Check all special needs that apply:

- Vision Hearing Morbid Obesity Learning Disability
 Language Limitations Other Impaired Mental Status
 Low Literacy Impaired Mobility

*** DSMT Content**

X All ten content areas, as appropriate

- Monitoring diabetes Diabetes as disease process
 Psychological adjustment Physical activity
 Nutritional management Goal setting, problem solving
 Medications Prevent, detect and treat acute complications
 Preconception/pregnancy management or gestational diabetes management Prevent, detect and treat chronic complications

* DIAGNOSIS

Please send recent labs for patient eligibility & outcomes monitoring

- Type 1 uncontrolled 250.03 250.01 Type 1 controlled
 Type 2 uncontrolled 250.02 250.00 Type 2 controlled
 Gestational diabetes 648.8 Other _____

Complications/Comorbidities

Check all that apply:

- Hypertension Dyslipidemia Stroke
 Neuropathy Nephropathy PVD
 Renal disease Retinopathy CHD
 Non-healing wound Pregnancy Obesity
 Mental/affective disorder Other _____

MEDICAL NUTRITION THERAPY (MNT)

***3 hours initial MNT in the first calendar year, plus two hours follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis.**

** Check the type of MNT and/or number of additional hours requested:*

- Initial MNT Annual follow-up MNT
 Additional MNT services in the same calendar year, per RD recommendations _____ no. additional hrs. requested

Please specify change in medical condition, treatment and/or diagnosis:

CURRENT DIABETES MEDICATIONS

Specify type, dose and frequency

Oral:

Insulin:

Patient now uses: Pen Needle Pump

PATIENT BEHAVIOR GOALS/PLAN OF CARE

*Signature and UPIN # _____ *Date ____/____/____

Group/practice name, address and phone: _____