

Diabetes Services Order Form (DSME and MNT Services)

*Indicates required information for Medicare order

FAX COMPLETED FORM TO (325) 670-5310

PATIENT INFORMATION

Patient's Last Name _____ First Name _____ Middle _____

Birth Date _____ Insurance _____ Gender: Male Female

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Other Phone _____

Diabetes Self-Management Education (DSME) 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 DSME improves outcomes.

DIABETES SELF-MANAGEMENT EDUCATION (DSME)

Medicare: 10 hours initial DSME in 12 month period, plus 2 hours follow-up DSME annually

- | | |
|---|----------------|
| <input type="checkbox"/> Initial Group DSME | Up to 10 hours |
| <input type="checkbox"/> Follow Up DSME | Up to 2 hours |
| <input type="checkbox"/> Additional Insulin Training | Up to 2 hours |
| <input type="checkbox"/> Gestational Group | Up to 3 hours |
| <input type="checkbox"/> Continuous Glucose Monitoring: | Up to 2 hours |
| <input type="checkbox"/> Individual DSME | Up to 4 hours |

Patients with special needs requiring individual DSME

*Check all special needs that apply: Up to 7 hours

- Vision Hearing Physical Cognitive Impairment
 Language Limitations Other _____

DSME Content: All ten content areas as appropriate

- Monitoring Diabetes
- Psychological Adjustment
- Nutritional Management
- Medications
- Preconception/Pregnancy Management or Gestational Diabetes Management
- Prevent, Detect and Treat Acute complications
- Prevent, Detect and Treat Chronic Complications
- Physical Activity
- Goal Setting
- Problem Solving
- Diabetes as a Disease

* DIAGNOSIS

- Type 1 controlled Type 2 controlled Gestational
 Type 1 uncontrolled Type 2 uncontrolled Other _____

LABS

HbA1C _____
Total Cholesterol _____ HDL _____ LDL _____ TG _____
Microalbumin _____
OGTT Fasting _____ 1 hour _____ 2 hour _____ 3 hour _____
Height _____ Weight _____

MEDICAL NUTRITION THERAPY (MNT)

Medicare: 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 hours requested:

- Initial MNT Annual Follow Up MNT
 Additional MNT services in the same calendar year, per RD recommendation _____ number of hours

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

Complications/Comorbidities Check all that apply:

- | | | |
|--|---------------------------------------|----------------------------------|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Dyslipidemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Nephropathy | <input type="checkbox"/> PVD |
| <input type="checkbox"/> Renal Disease | <input type="checkbox"/> Retinopathy | <input type="checkbox"/> CHD |
| <input type="checkbox"/> Non-Healing Wound | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Mental Affective | | |
| <input type="checkbox"/> Other _____ | | |

*Healthcare Provider Signature _____

*Date _____

Physician Name _____

PHONE 325-670-2421



DIABETES SELF MANAGEMENT
EDUCATION AND MEDICAL
NUTRITION THERAPY

CC 17256

(PT IDENTIFICATION)

32-230 (12/16)