

# Diabetes Services Order Form (DSME and MNT Services)

\*Indicates required information for Medicare order

## 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**

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

- Initial Group DSME Up to 10 hours  
 Follow Up DSME Up to 2 hours  
 Additional Insulin Training Up to 2 hours  
 Gestational Group Up to 3 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  Gestational Diabetes  
 Type 2  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:

- Hypertension  Dyslipidemia  Stroke  
 Neuropathy  Nephropathy  PVD  
 Renal Disease  Retinopathy  CHD  
 Non-Healing Wound  Pregnancy  Obesity  
 Mental Affective  
 Other \_\_\_\_\_

\*Healthcare Provider Signature \_\_\_\_\_

\*Date \_\_\_\_\_

**PLEASE FAX COMPLETED FORM TO (325) 670-5310**

**PHONE 325-670-2421**



**DIABETES SELF MANAGEMENT  
EDUCATION AND MEDICAL  
NUTRITION THERAPY**

CC 17256

(PT IDENTIFICATION)

32-230 (06/11)