Fax completed form to Centralized Scheduling at (325) 670-4276 Phone (325) 670-4270

Name: _____ **Gender**: [] Male [] Female **DOB**: _____

Social Security Number: _____ **Phone**: _____ **ICD9 Code**:_____

Insurance Carrier: _____ **Physician:** _____

The patient has this
TYPE OF DIABETES:

[] Type 1
[] Type 2
[] Gestational
[] Pregnant with pre-existing diabetes
[] Pre-diabetes

***The patient has SPECIAL NEEDS requiring individual DSME:**
(Check all that apply)

[] Vision impairment
[] Hearing impairment
[] Physical Impairment
[] Cognitive Impairment
[] Language Barriers
[] Other: _____

The patient has the following
COMPLICATIONS or COMORBIDITIES:
(Check all that apply)

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

DIABETES SELF-MANAGEMENT EDUCATION TRAINING (DSME /DSMT)

Initial & follow-up DSME include individual assessment, education, & follow-up phone calls or appointments as appropriate. **For Medicare**: 10 hours initial DSME in 12 month period, plus 2 hours follow-up DSME annually. **Often insurance provides similar coverage**.

Check type of training services and number of hours requested:

[] **Initial Group (includes follow-up):** up to 10 hours
[] **Initial Individual (includes follow-up)** (special needs*): up to 7 hours
[] **Gestational Group:** up to 3 hours
[] **Insulin Administration:** up to 2 hours
[] **Follow-up only:** up to 2 hours
[] **Pump Training:** up to 10 hours
[] **Continuous Glucose Monitoring:** up to 2 hours
[] **Other request:** _____ ____# of hours requested

EDUCATION CONTENT includes ALL 10 content areas as appropriate:

* Monitoring diabetes
* Psychological Adjustment
* Nutritional Management
* Medications
* Preconception/pregnancy management
* Prevent detect, and treat chronic complications
* Physical Activity
* Goal setting, problem solving
* Prevent, detect, and treat acute complication
* Diabetes as a disease

MEDICAL NUTRITION THERAPY (MNT) : **Additional MNT hours available for change in medical condition, treatment and/or diagnosis. Often insurance will cover similarly.**

Type of MNT and/or number of additional hours requested:

[] Initial MNT (up to 3 hours per diagnosis – visits may vary in amount of time)
[] Annual follow-up MNT (up to 2 hours annually)
[] Additional MNT services in the same calendar year, per RD recommendation
[] * Other additional MNT hrs. requested _____

*** *For other additional MNT hours requested, please specify if there is a change in*:**

[] *medical condition* ---------- [] *treatment* ---------- [] *diagnosis* ----------

CURRENT DIABETES MEDICATIONS

Please specify type, dose, & frequency

[] **None –** dietary management only

[] **Oral**:_____

[] **Insulin**: _____
Patient now uses: [] Pen [] Needle [] Pump

LABS REQUESTED

A1c _____ Date of lab: _____
Total cholesterol _____ Date of labs: _____
HDL _____ LDL _____ TG _____
Microalbumin _____ Date of lab: _____
Glucose Tolerance Test (GTT) results: Date of labs: _____
fasting _____ 1 hour _____ 2 hour _____ 3 hour _____
Other : _____

HEALTH CARE PROVIDER SIGNATURE

By signing this order, the physician or qualified practitioner certifies that he/she is managing the beneficiary's diabetic condition, & the training describe in the plan of care is needed to ensure therapy compliance or to provide the beneficiary with the skills & knowledge to help manage the beneficiary's diabetes.

Signature: _____ Date:_____

CC 17256 (LABEL) 26-230 (08-29-08)

HENDRICK MEDICAL CENTER

PHYSICIAN ORDERS FOR DIABETES SELF-MANAGEMENT EDUCATION