Diabetes Wellness Education Services

DIABETES SELF-MANAGEMENT EDUCATION & SUPPORT REFERRAL FORM

Phone: (631) 687-4188 Fax: (631) 687-2879

A. PATIENT NAME: _____ **DOB:** _____

PATIENT PHONE: _____

For Medicare patients: All sections must be completed for referrals.*

DIAGNOSIS

☐ E10.65 Type 1, hyperglycemia ☐ E10.8 Type 1, unspecified complications ☐ E11.65 Type 2, hyperglycemia ☐ E11.8 Type 2, unspecified complications

☐ R73.09 Glucose intolerance, prediabetes ☐ O24.414 Gestational, insulin ☐ O24.414 Gestational, oral agent

☐ Other _____

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.

B. DIABETES SELF-MANAGEMENT EDUCATION (DSME) **Medicare: 10 hours initial DSME in 12 months, plus 2 hours follow-up annually.**

Check type of training and number of hours requested:

☐ Individual/group DSMT ☐ 10 hours or _____# hours requested

☐ Follow-up DSMT ☐ 2 hours or _____# hours requested

☐ Additional insulin training ____ # hours requested

***C.* EDUCATION NEEDED** **Patients who need **Individual instruction** in Comprehensive self- management skills require documentation of special need. See section D.*

☐ **Comprehensive self-management skills (GROUP)** ☐ Self glucose monitoring

☐ Comprehensive self-management skills (Individual) * ☐ Insulin pump Instruction

☐ Insulin instruct ☐ Gestational diabetes education/management during pregnancy

With few exceptions DMSE should be ordered as GROUP education (See section D).

D. PATIENTS WITH SPECIAL NEEDS REQUIRING INDIVIDUAL DSME

Check all that apply if your patient requires individual rather than group instruction:

☐ Vision ☐ Hearing ☐ Physical ☐ Cognitive impairment ☐ Language limitations

☐ other:_____

E. MEDICAL NUTRITION THERAPY ***Medicare*: 3 hours initial MNT** in the first calendar year, plus **two hours follow-up** MNT annually.

Medical Nutrition Therapy is a separate order for services of the Registered Dietitian.

Check type MNT and/or number of hours requested:

☐ Initial MNT ☐ Annual follow-up MNT ___ number of hours requested

☐ I hereby certify that I am managing this beneficiary's diabetes condition and that the above prescribed training is a necessary part of diabetes management. (For Medicare patients)

LIP signature:_____ Date: _____

Print name:_____ ID# _____

109 West Main Street