

*Indicates required information for Medicare order

PATIENT INFORMATION

Patient's Last Name _____ First Name _____ Middle _____

Date of Birth ____/____/____ Medicare HICN # _____ 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)

Medicare: 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:

- Initial group DSMT: 10 hours or ____ no. hrs. requested
- Follow-up DSMT: 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 Physical Cognitive Impairment
- Language Limitations Other _____

*** DSMT Content**

- 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 Type 1 controlled
- Type 2 uncontrolled Type 2 controlled
- Gestational diabetes 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)

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 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 _____ *Date ____/____/____

Group/practice name, address and phone: _____