DIABETES EDUCATION PROGRAM

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Tel: 321-268-6699/ Fax 321-268-6748
American Diabetes Association Recognized Program

PARRISH MEDICAL CENTER
DIABETES EDUCATION

Patient's Name: _____ Date of Birth: _____
Insurance #1: _____ #2 _____
Is Authorization Needed? □ YES □ No Home Tel: _____
If Needed: Authorization # _____ Work Tel: _____
# of Visits: _____ Exp. Date _____

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

DIAGNOSIS

Please send recent labs for patient eligibility & outcomes monitoring

□ Type 1 uncontrolled □ Type 1 controlled
□ Type 2 uncontrolled □ Type 2 controlled
□ Gestational □ New Onset
□ Prediabetes □ Other

Complications/Comorbidities – check all that apply:

□ 250.0 _____ diabetes w/o complications
□ 250.1 _____ diabetes w/ketoacidosis
□ 250.2 _____ diabetes w/hyperosmolarity
□ 250.3 _____ diabetes w/other coma
□ 250.4 _____ diabetes w/renal manifestations
□ 250.5 _____ diabetes w/ophthalmic manifestations
□ 250.6 _____ diabetes w/neurological manifestations
□ 250.7 _____ diabetes w/peripheral circulatory disorders
□ 250.8 _____ diabetes w/other specified manifestations
□ 250.9 _____ diabetes w/unspecified complications
□ 646.6 _____ Gestational diabetes
□ 585 _____ Chronic Renal Failure (non-dialysis)
□ V42.0 _____ Status post renal transplant

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 ____ # additional hours requested

PATIENT INSTRUCTIONS:

1. Please call 321-268-6699 to schedule your appointment.
2. It is your responsibility to verify insurance coverage for "Diabetes Self Management Training" Please contact the business office at 321-268-6158 if you need financial assistance.
3. You must **BRING THIS FORM WITH YOU** to your first appointment.
4. Bring medication list, blood glucose log, and blood glucose meter to **ALL** visits.

DSMT CONTENT

□ All 10 content areas, as appropriate
□ Monitoring Diabetes □ Diabetes as disease process
□ Psychological adjustment □ Physical activity
□ Nutritional management □ Medications
□ Goal setting, problem solving
□ Prevent, detect and treat acute complications
□ Prevent, detect and treat chronic complications
□ Preconception/pregnancy management or gestational diabetes management

Patients with special needs who require individual DSMT

* Check all special needs that apply:

□ Vision □ Hearing □ Physical
□ Language limitation □ Cognitive Impairment
□ Other _____

RECENT LAB RESULTS: (REQUIRED)

Blood Glucose_____ A1C _____
Cholesterol _____ Triglycerides _____
HDL _____ LDL _____
OGTT: FBS _____ 1 hr. _____
2 hr. _____ 3 hr. _____

SPECIAL INSTRUCTIONS/PHYSICIAN ORDERS:

*A copy of recent labs that reflect Diagnosis of Diabetes or poor control is required.

DIAGNOSIS:

1. FBS >126 mg/dl x 2 tests
2. Random >200 mg/dl with symptoms

*PMC Lab may perform A1C Level if none available within the last 60 days.

_____
_____
_____
_____

NOTE: Physician MUST sign this referral, send recent labs, and check off diagnosis/complications.

Physician's Signature: _____
Date: _____
Physician's Name (Printed): _____
NPI: _____