

DIABETES SELF-MANAGEMENT EDUCATION AND MEDICAL NUTRITIONAL THERAPY
330 N. Clyde Morris Blvd., Suite 9, Daytona Beach, FL 32114 Phone (386) 226-4518
FAX orders (along with labs and progress notes) to: (386)238-3228

Name: _____ FHCP # _____

Phone # _____ Cell Phone # _____ DOB: _____

Diabetes Self-Management (DSMT):

(Medicare-10hrs initial DSMT in 12 month period, plus 2 hrs. follow-up annually)

- Initial DSMT Group (10 hrs.) ____ # hrs. requested Glucometer Training: Yes No
- Follow-up DSMT (2 hrs.) _____ # hrs. requested CGMS testing (clinic)
- Insulin Start Training: Type of Insulin: _____ Amount of Insulin: _____ Time(s) _____
- Patients with special needs requiring individual DSMT training (**Check all that apply**):
 - Vision Hearing Physical Language Limitations Other _____

Diagnosis:

Diagnosis code:

- Type 1 Controlled/Uncontrolled _____
- Type 2 Controlled/Uncontrolled _____
- Gestational _____

DSMT CONTENT Check education desired **All 10 content areas, as appropriate** or:

- Monitoring Diabetes
- Psychological adjustment
- Nutritional management
- Goal setting, problem solving
- Prevent, detect and treat acute complications
- Diabetes disease process
- Physical activity
- Medications
- Prevent, detect and treat chronic complications
- Preconception/pregnancy or gestational management

Medical Nutrition Therapy (MNT): *Medicare coverage: 3 hrs. initial MNT in the first calendar year, plus 2 hrs. 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 3 hrs or ____ # hrs requested Annual follow-up MNT 2 hrs or ____ #hrs requested
- Additional MNT services in the same calendar year, per RD recommendations _____ # additional hrs. requested

Please specify change in medical condition, treatment and/or diagnosis: _____

- Nutritional Counseling:**
- Healthy Heart Eating (Lipid)
 - Eat Right Move Right Adult Weight Management Program
 - Increased Risk for Diabetes (Pre-diabetes)
 - Other (specify) _____
 - Diagnosis code _____

Lab Information: (Required) Glucose: _____ A1C: _____ Cholesterol: _____ HDL: _____ LDL: _____

Triglycerides: _____ Weight: _____ Height: _____ BMI: _____

Medicare coverage of DSMT and MNT requires the physician to provide documentation of a diagnosis of diabetes based on one of the following: FBS >126 mg/dl x 2 tests Random > 200 mg/dl with symptoms

Physician Name and Provider Number

Date