

Diabetes Services Order Form (DSMT and MNT Services)

*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:

- | | |
|---|--|
| <input type="checkbox"/> Initial group DSMT: | <input type="checkbox"/> 10 hours or ____ no. hrs. requested |
| <input type="checkbox"/> Follow-up DSMT: | <input type="checkbox"/> 2 hours or ____ no. hrs. requested |
| <input type="checkbox"/> Additional insulin training: | ____ no. hrs. requested |

* Patients with special needs requiring individual DSMT

Check all special needs that apply:

- | | | | |
|---|--------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Vision | <input type="checkbox"/> Hearing | <input type="checkbox"/> Physical | <input type="checkbox"/> Cognitive Impairment |
| <input type="checkbox"/> Language Limitations | <input type="checkbox"/> Other _____ | | |

* DSMT Content

- | | |
|--|--|
| <input type="checkbox"/> All ten content areas, as appropriate | |
| <input type="checkbox"/> Monitoring diabetes | <input type="checkbox"/> Diabetes as disease process |
| <input type="checkbox"/> Psychological adjustment | <input type="checkbox"/> Physical activity |
| <input type="checkbox"/> Nutritional management | <input type="checkbox"/> Goal setting, problem solving |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Prevent, detect and treat acute complications |
| <input type="checkbox"/> Preconception/pregnancy management or gestational diabetes management | <input type="checkbox"/> Prevent, detect and treat chronic complications |

* DIAGNOSIS

Please send recent labs for patient eligibility & outcomes monitoring

- | | |
|---|--|
| <input type="checkbox"/> Type 1 uncontrolled | <input type="checkbox"/> Type 1 controlled |
| <input type="checkbox"/> Type 2 uncontrolled | <input type="checkbox"/> Type 2 controlled |
| <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Other _____ |

Complications/Comorbidities

Check all that apply:

- | | | |
|--|---------------------------------------|----------------------------------|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Dyslipidemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Nephropathy | <input type="checkbox"/> PVD |
| <input type="checkbox"/> Renal disease | <input type="checkbox"/> Retinopathy | <input type="checkbox"/> CHD |
| <input type="checkbox"/> Non-healing wound | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Mental/affective disorder | <input type="checkbox"/> 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:

- | | |
|--|---|
| <input type="checkbox"/> Initial MNT | <input type="checkbox"/> Annual follow-up MNT |
| <input type="checkbox"/> 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 and UPIN # _____ *Date ____/____/____

Group/practice name, address and phone: _____

Revised 8/31/05 by the American Dietetic Association and the American Association of Diabetes Educators after substantial review and consultation. Authors do not recommend or endorse any revisions or modifications.