DIABETES EDUCATION
PHYSICIAN ORDER FORM

PATIENT INFORMATION

Patient Name: ___________________________________________ Date of Birth: __________________________

[ ] English-speaking [ ] Non-English Speaking (language): __________________________

Address: ________________________________________________

Phone: (Primary) __________________________ (Secondary) __________________________

DIAGNOSIS

[ ] Type 2, newly diagnosed [ ] Type 1, newly diagnosed [ ] Gestational diabetes [ ] Pre-diabetes

[ ] Type 2, uncontrolled [ ] Type 1, uncontrolled [ ] Pregestational diabetes [ ] Other: __________________________

MEDICAL NECESSITY

[ ] New Onset Diabetes Mellitus [ ] Change in Treatment Plan [ ] Inadequate Glycemic Control

DIABETES SELF-MANAGEMENT TRAINING (DSMT) and MEDICAL NUTRITION THERAPY (MNT)

Medicare covers 10 hours initial DSMT in 12-month period, plus 2 hours follow-up DSMT annually. Medicare MNT coverage includes 3 hours initial MNT in first calendar year, plus two hours follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment, and/or diagnosis.

Check education program and number of hours requested:

[ ] Initial DSMT - Comprehensive Program or [ ] Follow-up DSMT - 2 hours

*approximate hours for education programs listed below or physician can specify ____ hours of DSMT

Type 2 {8-10 hours}, Type 1 {6-8 hours}, Gestational {4-10 hours}, Pre-gestational {4-10 hours}, Pre-Diabetes {4 hours}

[ ] Medication Instruction (insulin or other injectible) [ ] Center to titrate per protocol [ ] Physician to titrate medication

*Name of medication: __________________________________________ Dose: __________________________

[ ] Initial MNT - 3 hours or [ ] Follow-Up MNT – 2 hours

[ ] Additional MNT services in the same calendar year, per dietitian recommendations ____ # additional hours requested

DSMT Content: All ten content areas, as appropriate, will be covered unless otherwise specified.

[ ] Monitoring diabetes [ ] Diabetes as disease process [ ] Medications [ ] Psychological adjustment

[ ] Nutritional management [ ] Physical activity [ ] Goal setting, problem solving [ ] Preconception/pregnancy

[ ] Prevent, detect and treat acute complications [ ] Prevent, detect and treat chronic complications

Patient CAN NOT effectively participate in group instruction because of the following special needs:

[ ] Vision/Hearing [ ] Language Limitations [ ] Cognitive Impairment [ ] Other: __________________________

FAX completed form, COPY of insurance card, and labs (hemoglobin A1C, lipids, oral glucose tolerance test) to location of your choice:

[ ] Baylor Ft. Worth (All Saints) 817-922-2192 (phone) 817-922-1951 (fax)

[ ] Baylor Ft. Worth (Southwest) 817-370-5988 (phone) 817-370-5981 (fax)

[ ] Baylor Grapevine 817-424-4542 (phone) 817-424-4550 (fax)

[ ] Baylor Garland 972-487-5483 (phone) 972-485-3016 (fax)

[ ] Baylor Irving 972-579-4350 (phone) 972-579-4355 (fax)

[ ] Baylor Plano 469-814-6896 (phone) 469-814-6761 (fax)

[ ] Baylor Dallas (Ruth Collins & Ruth Collins at Mesquite) 214-820-8988 (phone)

[ ] Baylor Waxahachie 972-923-8047 (phone) 972-937-2063 (fax)

[ ] Baylor Ft. Worth (Southwest) 817-370-5988 (phone)

Physician Name (printed): __________________________ Phone #: __________________________

Signature: __________________________________________ (signature stamps are not acceptable)

Referral Date: __________________________ Time: __________________________