

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:

<input type="checkbox"/> Baylor Ft. Worth (All Saints) 817-922-2192 (phone) 817-922-1951 (fax)	<input type="checkbox"/> Baylor Ft. Worth (Southwest) 817-370-5988 (phone) 817-370-5981 (fax)	<input type="checkbox"/> Baylor Grapevine 817-424-4542 (phone) 817-424-4550 (fax)
<input type="checkbox"/> Baylor Garland 972-487-5483 (phone) 972-485-3016 (fax)	<input type="checkbox"/> Baylor Irving 972-579-4350 (phone) 972-579-4355 (fax)	<input type="checkbox"/> Baylor Plano 469-814-6896 (phone) 469-814-6761 (fax)
<input type="checkbox"/> Baylor Dallas (Ruth Collins & Ruth Collins at Mesquite) 214-820-8988 (phone) 214-820-8985 (fax)		<input type="checkbox"/> Baylor Waxahachie 972-923-8047 (phone) 972-937-2063 (fax)

Physician Name (printed): _____ Phone #: _____ Fax #: _____

Signature: _____ Referral Date: _____ Time: _____
(signature stamps are not acceptable)

BAYLOR HEALTH CARE SYSTEM



BHCS-49245 (08/10)

**DIABETES EDUCATION
PHYSICIAN ORDER FORM**