



Referral Form: Diabetes Self-Management Training (DSME) and Medical Nutrition Therapy (MNT)

1407 Whisenant Drive
Duncan, OK 73533

Phone: 580-251-8461 Fax: 580-251-8869

Patient Name _____ DOB _____ Phone _____ Gender _____ SSN _____

Address _____ City _____ State _____ Zip _____

Ht. _____ Wt. _____ For GDM: pre-pregnancy Wt. _____ Pregnancy EDC _____

Lab Results: Date _____ HgbA1C _____

Cholesterol: Total _____ HDL _____ LDL _____ Tryglycerides _____

Diagnosis/Medical Necessity:

- | | |
|--|---|
| <input type="checkbox"/> Type I Controlled | <input type="checkbox"/> Metabolic Syndrome |
| <input type="checkbox"/> Type I Uncontrolled | <input type="checkbox"/> Hypertriglyceridemia |
| <input type="checkbox"/> Type II Controlled | <input type="checkbox"/> Mixed Hyperlipidemia |
| <input type="checkbox"/> Type II Uncontrolled | <input type="checkbox"/> Hypercholesterolemia |
| <input type="checkbox"/> Pregnancy W/Pre existing Diabetes | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Abnormal Weight Gain |
| <input type="checkbox"/> Pre-Diabetes | <input type="checkbox"/> Abnormal Weight Loss |
| <input type="checkbox"/> Hypoglycemia, unspecified | BMI _____ (>30 BMI required for Medicare Eligibility) |
| <input type="checkbox"/> Abnormal Glucose Tolerance Test | <input type="checkbox"/> Other: _____ |

Patient Information/Comorbidities:

- Newly Diagnosed
- Inadequate Control
- Recurrent hypoglycemia or hypoglycemia unawareness
- Recent/frequent hospitalization DKA or HHS
- Change in treatment regime

Chronic complications/Comorbidities:

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Retinopathy | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Nephropathy | <input type="checkbox"/> CVD |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> PVD |
| <input type="checkbox"/> Dermopathy | <input type="checkbox"/> CVA |
| <input type="checkbox"/> Renal Disease | |
| <input type="checkbox"/> Dyslipidemia | |
| <input type="checkbox"/> Non-Healing wound: Location _____ | |

Exercise: Medically released for exercise? Y N

Training Education Requested:

- DSMT initial training/comprehensive group class (10 hours)
Content includes: Disease process, monitoring, physical activity, nutritional management, medications, psychological adjustment, goal setting, problem solving, preconception management, prevent, detect & treat acute and chronic complications.
- Pregnancy with diabetes (type I, II, Gestational)
- Individual training due to learning barrier or special needs (10 hours)
Insulin management
- Existing Barriers to learning/special needs: Cognitive impairment Hearing Impairment Physical Impairment
- Psychological/Mental Disorder Visual Impairment Learning Disabilities _____
- Language Limitations _____ Other _____
- DSMT follow up (Medicare 2 hour each follow up year)
- Medical Nutrition Therapy (Medicaid 6 hr per year, Medicare 3 hr during the initial year & after that 2 hr for follow up annually)

DEFINITION OF DIABETES (MEDICARE):

Medicare coverage of DSMT and MNT requires the physician to provide documentation of a diagnosis of diabetes based on one of the following:

- a fasting blood sugar greater than or equal to 126 mg/dl on two different occasions or..
- a 2 hour post-glucose challenge greater than or equal to 200 mg/dl on 2 different occasions or..
- a random glucose test over 200 mg/dl for a person with symptoms of uncontrolled diabetes

Source: Volume 68, #216, November 7, 2003, page 63,261/Federal Register. Other payors may have other coverage requirements.

Physician's Signature _____ Print name clearly _____

Date/Time: _____ Phone: _____ Fax: _____