BIG HORN NUTRITION

Diabetes Self-Management Education Referral

Tenika Eardley RDN, LD

Patient Name: _____DOB: _____/_____/____ Phone Number: _____

Diagnosis and or Problems (Please check all that apply)

Type 2 Diabetes - Dx code_____ Uncontrolled _____ Controlled _____ New Dx. _____

Type 1 Diabetes - Dx code _____ Uncontrolled _____ Controlled _____ New Dx. _____ Gestational - Dx code _____ EDC: _____ Other: _____ SDOH Dx code: _____

Diabetes Self-Management Education

Diabetes self-management education and support/training (DSMES/T) and medical nutrition therapy (MNT) are separate and complementary services to improve diabetes self-care. Individuals may be eligible for both services in the same year. Research indicates MNT combined with DSMES/T improves outcomes.

☐ **DSMES/T:** 10 hours initial DSMES/T in 12-month period from the date of first session with written referral from the treating qualified provider, plus 2 hours follow-up per calendar year.

☐ **MNT:** 3 hrs. initial MNT in the first calendar year, plus 2 hours follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis with a written referral from the treating physician. Medicare coverage of DSMES/T and MNT requires the treating qualified provider to provide documentation of a diagnosis of diabetes based on- A1c greater than or equal to 6.5%

☐ Fasting blood glucose greater than or equal to 126 mg/dl on two different occasions **(Medicare Clients)** -or -

☐ 2-hour post-glucose challenge greater than or equal to 200 mg/dl on 2 different occasions random glucose test over 200 mg/dl for a person with symptoms of uncontrolled diabetes. **(Medicare Clients)**

☐ If more than 1 hour (1:1) for initial training, please check if special needs that apply: _____

Other payers may have other coverage requirements.(Last Reviewed: September 30, 2022 Source: Centers for Disease Control and Prevention)

If patient cannot attend group education, please indicate reason:_____

_____ Injectable medication education (insulin and incretins or other)

*Name of Medication/s and dosing:_____

_____

_____ **Lifestyle Balance; Diabetes Prevention Program (DPP)**

_____ **Continuous Glucose Monitoring**

_____ **Insulin Pump Therapy**

(You may now place medication therapy names on this order form)

Please if available send a copy of the patient's demographics sheet, recent medications and/or following labs if available. 2 - Blood Glucose Levels, A1C with dates.

* Microablbumin * Lipid Profile * Bun/Creat/GFR * Date of last eye and foot exam _____

RN/RD/PharmD/CDCES verbal order: _____ Date: _____ Time:_____

Provider's signature: _____ NPI: _____ Date: _____

***Referral form and all medical records may be to be sent to/or Fax number: 307-206-8995**

Office Phone: 307-679-4639 FAX: 307-206-8995

ADCES DEAP DIABETES EDUCATION ACCREDITATION PROGRAM