Saint Joseph Health System
Mishawaka/Plymouth, IN

DIABETES SELF-MANAGEMENT EDUCATION/TRAINING (DSME/T) REFERRAL FORM

Fax referral to Diabetes Educator @ 574-335-0820. Educator will call the patient to schedule.

REQUIRED

ICD-10 code: _____ **Diagnosis:** _____

Co-morbidities: _____

PATIENT INFORMATION

_____ _____ _____
Last name *First name* *Phone*

_____ _____ _____ _____
Street address *City* *State* *ZIP*

_____ _____ ☐ English ☐ Spanish ☐ Other _____
Date of Birth *Insurance* *Primary language*

DIABETES EDUCATION/TRAINING SERVICES REQUESTED (PLEASE CHECK)

☐ **Initial comprehensive program***
Diabetes Self-Management Education / Training (DSME/T) and Medical Nutrition Therapy (MNT). Up to 10 hours of group DSME/T and 3 hours of individual MNT
☐ **Annual Review:** up to 2 hours each of DSME/T and MNT for Individuals who have previously attended DSME/T and/or MNT.

☐ **Diabetes & Pregnancy group class**
RN & RD up to 2 hours ☐ GDM ☐ T1DM ☐ T2DM

Initial class content is listed below. Please select education focus area(s) needed if individual education is selected.
☐ *Pathophysiology* ☐ *psychological adjustment* ☐ *monitoring* ☐ *medication* ☐ *nutritional management* ☐ *physical activity* ☐ *problem solving* ☐ *prevent/detect/treat acute and chronic complications* ☐ *goal setting* ☐ *preconception, pregnancy in diabetes.*
Individual education will be provided if no group class is available for greater than two months.

☐ **Individual with RN**
Content areas are identified by the DSME/T team on assessment or as specific content areas are selected by the ordering provider under initial class content.

Check reason prohibiting group education:
☐ Cognitive ☐ Physical ☐ Skills Training
☐ Language_____
Medical Interpreter will be provided for language other than English.

Monitor Training (RN)
☐ Standard Glucose Monitor
☐ Continuous Glucose Monitor (CGM)
Manufacturer: _____

Injection training (RN)
Insulin: ☐ Pen ☐ Syringe/Vial
Name/Dose/Time: _____
☐ Non-Insulin Injectable
Name/Dose/Time: _____

CLINICAL DATA (REQUIRED) *

Blood glucose #1: _____ date _____ **Ht**. _____ **Wt**. _____

Blood glucose #2: _____ date _____ **EDC** (if pregnant) _____

A1c: _____ date _____

OGTT: date _____ fasting _____ 1 hour _____ 2 hour _____ 3 hour _____

PROVIDER INFORMATION

Signature: _____ NPI #: _____ Date: _____ Time: _____

Please print provider's name: _____

Group name and address: _____

Office phone #: _____ Office fax #: _____

MEDICARE INFORMATION

- ** The physician is required to provide documentation of a diagnosis of diabetes based on one of the following:*
  - *Fasting blood glucose results greater than or equal to 126 mg/dl on two different occasions* <u>OR</u>
  - *A 2-hour post-glucose challenge greater than or equal to 200 mg/dl on two different occasions* <u>OR</u>
  - *A random glucose test over 200 mg/dl with symptoms of uncontrolled diabetes*
- *Medicare benefit:*
  - *10 hours in the 12 months period from the date of the initial class/visit*
  - *2 hours per calendar year thereafter for annual refresher with RN and/or RD*

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DIABETES SELF-MANAGEMENT EDUCATION/TRAINING (DSME/T) REFERRAL FORM

Printing Instructions

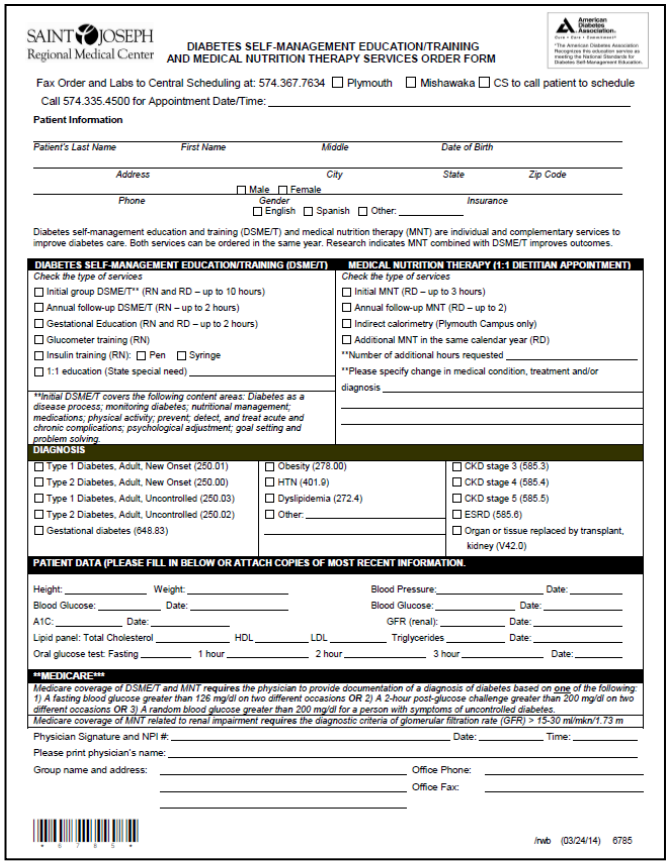
Title: DIABETES SELF-MANAGEMENT EDUCATION/TRAINING (DSME) REFERRAL FORM

Entity: SJRMC

Printer Info: 20# White
Black ink
5 hole punch top

PDF File in Forms Directory

of pages: 1



SAINT JOSEPH Regional Medical Center

DIABETES SELF-MANAGEMENT EDUCATION/TRAINING AND MEDICAL NUTRITION THERAPY SERVICES ORDER FORM

Fax Order and Labs to Central Scheduling at: 574.367.7634 ☐ Plymouth ☐ Mishawaka ☐ CS to call patient to schedule
Call 574.335.4500 for Appointment Date/Time: _____

Patient Information

_____
Patient's Last Name *First Name* *Middle* *Date of Birth*

_____
Address *City* *State* *Zip Code*

_____
Phone *Gender* ☐ Male ☐ Female ☐ English ☐ Spanish ☐ Other: _____ *Insurance*

Diabetes self-management education and training (DSME/T) and medical nutrition therapy (MNT) are individual and complementary services to improve diabetes care. Both services can be ordered in the same year. Research indicates MNT combined with DSME/T improves outcomes.

DIABETES SELF-MANAGEMENT EDUCATION/TRAINING (DSME/T)	MEDICAL NUTRITION THERAPY (1:1 DIETITIAN APPOINTMENT)
Check the type of services	*Check the type of services*
☐ Initial group DSME/T** (RN and RD – up to 10 hours)	☐ Initial MNT (RD – up to 3 hours)
☐ Annual follow-up DSME/T (RN – up to 2 hours)	☐ Annual follow-up MNT (RD – up to 2)
☐ Gestational Education (RN and RD – up to 2 hours)	☐ Indirect calorimetry (Plymouth Campus only)
☐ Glucometer training (RN)	☐ Additional MNT in the same calendar year (RD)
☐ Insulin training (RN): ☐ Pen ☐ Syringe	**Number of additional hours requested _____
☐ 1:1 education (State special need) _____	**Please specify change in medical condition, treatment and/or diagnosis _____
***Initial DSME/T covers the following content areas: Diabetes as a disease process; monitoring diabetes; nutritional management; medications; physical activity; prevent, detect, and treat acute and chronic complications; psychological adjustment; goal setting and problem solving.*	

DIAGNOSIS

☐ Type 1 Diabetes, Adult, New Onset (250.01)	☐ Obesity (278.00)	☐ CKD stage 3 (585.3)
☐ Type 2 Diabetes, Adult, New Onset (250.00)	☐ HTN (401.9)	☐ CKD stage 4 (585.4)
☐ Type 1 Diabetes, Adult, Uncontrolled (250.03)	☐ Dyslipidemia (272.4)	☐ CKD stage 5 (585.5)
☐ Type 2 Diabetes, Adult, Uncontrolled (250.02)	☐ Other: _____	☐ ESRD (585.6)
☐ Gestational diabetes (648.83)		☐ Organ or tissue replaced by transplant, kidney (V42.0)

PATIENT DATA (PLEASE FILL IN BELOW OR ATTACH COPIES OF MOST RECENT INFORMATION.

Height: _____ Weight: _____ Blood Pressure: _____ Date: _____
Blood Glucose: _____ Date: _____ Blood Glucose: _____ Date: _____
A1C: _____ Date: _____ GFR (renal): _____ Date: _____
Lipid panel: Total Cholesterol _____ HDL _____ LDL _____ Triglycerides _____ Date: _____
Oral glucose test: Fasting _____ 1 hour _____ 2 hour _____ 3 hour _____ Date: _____

MEDICARE*

Medicare coverage of DSME/T and MNT requires the physician to provide documentation of a diagnosis of diabetes based on one of the following: 1) A fasting blood glucose greater than 126 mg/dl on two different occasions OR 2) A 2-hour post-glucose challenge greater than 200 mg/dl on two different occasions OR 3) A random blood glucose greater than 200 mg/dl for a person with symptoms of uncontrolled diabetes.
Medicare coverage of MNT related to renal impairment requires the diagnostic criteria of glomerular filtration rate (GFR) > 15-30 ml/mkn/1.73 m

Physician Signature and NPI #: _____ Date: _____ Time: _____
Please print physician's name: _____
Group name and address: _____ Office Phone: _____
_____ Office Fax: _____
_____

/rwb (03/24/14) 6785