CRESTWOOD MEDICAL CENTER

Diabetes Education Referral Form

PATIENT INFORMATION

/ /

Patient's Last Name | First Name | Middle | Date of Birth

Address | City | State | Zip Code

Home Phone | Work Phone | e-mail address

Primary Insurance | Policy Number | Group Number

/ /

Policy Holder's Name | Policy Holder's Date of Birth

Recent HbA1C: ___________ Date of test results: ___/____/______

* DIAGNOSIS:

****Please send recent labs for patient eligibility & outcomes monitoring****

- ☐ Type 2 w/o complications (E11.9)
- ☐ Type 2 with unspecified complications (E11.8)
- ☐ Type 1 w/o complications (E10.9)
- ☐ Type 1 with unspecified complications (E10.8)
- ☐ Long term/current Insulin use (Z79.4) ☐ Other ________________

RETURN/FAX FORM TO:

DIABETES SELF-MANAGEMENT TRAINING (DSMT) & MEDICAL NUTRITION THERAPY (MNT) SERVICES TO BE PERFORMED

Medicare coverage: 10 hours DSMT & 3 hours MNT in initial 12-month period, plus 2 hours DSMT & 2 hours MNT follow-up annually.

☐ Initial DSMT **and** Initial MNT (1h individual + 4 h DSMT Class + 2 hour MNT class)

10 DSMT topics taught as needed* as 1 hour individual + group UNLESS **Special Need** checked below, then all individual.

Special Need: ___Vision __Non-Ambulatory ___Physical Disability ___Hearing ___Cognitive ___Language ___Other____________

*OR only these topics: __SMBG __Nutrition __Exercise __Medication __Goal Setting & Problem-Solving __Coping-Stress Control __Acute Complications __Chronic Complications __Pathophysiology

☐ Annual follow-up DSMT **and** Annual follow-up MNT (2h DSMT +2 hour MNT class)

☐ Additional Insulin Training

***Physician Signature: ______________________________ *Date: ___/____/________**

Physician name (printed) and NPI: ______________________/____________________

Physician signature indicates DSME/MNT is medically necessary for this patient's diabetes control. For more information, please call 256-429-4061.