LOVE OAK

805 W Main St, Eastland, TX 76448 • (254) 629-1791

Diabetes Self-Management Education/Training Order Form

PATIENT INFORMATION

PATIENT NAME:	DOB:	SEX: ☐M ☐F
PATIENT ADDRESS:		
HOME PHONE:	CELL PHONE:	EMAIL:

Medicare coverage: 10 hrs initial DSMT in 12 month period from the date of first class or visit.

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

☐ INITIAL GROUP DSME/T: 10 HOURS (1 INDIVIDUAL + 9 GROUP) ONCE IN A LIFETIME BENEFIT. EXPIRES AFTER 12 MONTHS.
☐ FOLLOW-UP DSME/T: 2 HOURS (EITHER GROUP OR INDIVIDUAL) EVERY CALENDAR YEAR AFTER INITIAL BENEFIT IS USED.

PATIENTS WITH SPECIAL NEEDS REQUIRING INDIVIDUAL (1 ON 1) DSME/T

CHECK ALL SPECIAL NEEDS THAT APPLY:

☐ VISION ☐ HEARING ☐ PHYSICAL
☐ COGNITIVE IMPAIRMENT ☐ LANGUAGE LIMITATIONS ☐ ADDITIONAL TRAINING

☐ OTHER________________________________

DSME/T CONTENT

☐ MONITORING DIABETES ☐ DIABETES DISEASE PROCESS ☐ PSYCHOLOGICAL ADJUSTMENT
☐ PHYSICAL ACTIVITY ☐ NUTRITIONAL MANAGEMENT ☐ GOAL SETTING, PROBLEM SOLVING
☐ MEDICATIONS ☐ PREVENT, DETECT AND TREAT ACUTE COMPLICATIONS
☐ PREVENT, DETECT AND TREAT CHRONIC COMPLICATIONS ☐ PRECONCEPTION/PREGNANCY MANAGEMENT OR GDM

☐ OTHER________________________________

DIAGNOSIS (PLEASE SEND RECENT LABS FOR PATIENT ELIGIBILITY & OUTCOMES MONITORING)

☐ TYPE 1 ☐ TYPE 2 ☐ GESTATIONAL | DIAGNOSIS CODE:

GLUCOSE ______________MG/DL ☐ FASTING ☐ POSTPRANDIAL

A1C _______________

REASON FOR REFERAL

☐ NEW DX ☐ HYPOGLYCEMIA ☐ HYPERGLYCEMIA ☐ FREQ. ER VISITS
☐ RECENT HOSPITAL ADMISSION ☐ OTHER__________________________

Medicare coverage of DSMT 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;
- 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.

COMPLICATIONS / COMORBIDITIES

CHECK ALL THAT APPLY:

☐HYPERTENSION ☐ DYSLIPIDEMIA ☐STROKE ☐ NEUROPATHY ☐ PVD ☐ KIDNEY DISEASE
☐CHD ☐ NON-HEALING WOUND ☐ PREGNANCY ☐ OBESITY ☐ MENTAL/AFFECTIVE DISORDER

☐OTHER________________________________

I certify that I am the provider treating the participant's diabetes and that DSMT is needed to provide the beneficiary with the skills and knowledge to help self-manage their condition.

Signature and NPI # ______________________________ **Date** _____/_____/_______

Group/practice name, address and phone: ______________________________