



DOCTOR'S ORDERS

DIABETES SERVICES ORDER FORM (DSMT AND MNT SERVICES)

Boise: 208-331-1155 Fax: 208-383-0190
Meridian/Nampa: 208-884-4220 Fax: 208-855-4822
www.hdiabetescenter.org

(DSMT and MNT services may be ordered in the same year)

Date of Order:	Provider's Phone #:	Provider's Fax #:
Patient Name:	Date of Birth:	Phone Number:
Patient Address:	City:	State: Zip:

In order to triage your patient appropriately, please supply any relevant clinical information and recent lab (A1C and lipids)

Reason for Service (Diagnosis, Sign or Symptom): (Required)		<input type="checkbox"/> Type 1/Pregnant
<input type="checkbox"/> Type 1 <input type="checkbox"/> New onset <input type="checkbox"/> Metabolic Syndrome	<input type="checkbox"/> Type 2/Pregnant	<input type="checkbox"/> Pre Diabetes
<input type="checkbox"/> Type 2 <input type="checkbox"/> New onset <input type="checkbox"/> Impaired Glucose tolerance	<input type="checkbox"/> Gestational	<input type="checkbox"/> Other: _____

Complications / Co-Morbidities					
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Mental/Affective Disorder	<input type="checkbox"/> Obesity	<input type="checkbox"/> Stroke	<input type="checkbox"/> Celiac Disease	
<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Dyslipidemia	<input type="checkbox"/> Nephropathy	<input type="checkbox"/> PVD	<input type="checkbox"/> Transplant (type)	
<input type="checkbox"/> Renal Disease	<input type="checkbox"/> Gastroparesis	<input type="checkbox"/> Retinopathy	<input type="checkbox"/> CAD		

DIABETES SELF-MANAGEMENT TRAINING (DSMT)

Medicare: 10 hours initial DSMT in 12 month period, plus 2 hours follow-up DSMT annually. First training session may be an individual session, but subsequent sessions will be group sessions unless special needs are identified below.

<p>Check type of training services and number of hours requested: (Required)</p> <p><input type="checkbox"/> Initial Training: <input type="checkbox"/> 10 hours or <input type="checkbox"/> _____ # hours</p> <p><input type="checkbox"/> Follow Up: <input type="checkbox"/> 2 hours or <input type="checkbox"/> _____ # hours</p> <p>*Patient with special needs requiring individual DSMT <i>Check all that apply:</i></p> <p><input type="checkbox"/> Vision <input type="checkbox"/> Physical <input type="checkbox"/> Cognitive Impairments</p> <p><input type="checkbox"/> Hearing <input type="checkbox"/> Interpreter needed <input type="checkbox"/> Language Limitations</p> <p><input type="checkbox"/> Other: _____ <input type="checkbox"/> Disease state <input type="checkbox"/> Emotional</p> <p>PATIENT BEHAVIOR GOALS/PLAN OF CARE:</p> <p><input type="checkbox"/> Help patient select self care goals and communicate to me.</p> <p><input type="checkbox"/> Reinforce plan patient and I have agreed to as follows: BG test frequency _____ Activity plan _____ Nutrition plan _____ Low BG treatment _____ High BG treatment _____ Coping techniques _____ Medications and dose as listed below.</p>	<p>*Need for Diabetes Education (Required) <i>Check all that apply</i></p> <p><input type="checkbox"/> New Diagnosis</p> <p><input type="checkbox"/> Change from diet to orals <input type="checkbox"/> Change from orals to insulin</p> <p><input type="checkbox"/> Two A1c's greater than 8.5 (3 or more months apart)</p> <p><input type="checkbox"/> Severe hypo/hyperglycemia in the past year with ER or hospital visit</p> <p>*DSMT Content (Required)</p> <p><input type="checkbox"/> All ten areas as appropriate</p> <p><input type="checkbox"/> Monitoring diabetes <input type="checkbox"/> Goal setting, problem solving</p> <p><input type="checkbox"/> Physical activity <input type="checkbox"/> Nutritional Management</p> <p><input type="checkbox"/> Medications <input type="checkbox"/> Coping</p> <p><input type="checkbox"/> Prevent, detect, and treat acute complications</p> <p><input type="checkbox"/> Preconception/pregnancy or gestational diabetes management</p> <p><input type="checkbox"/> Diabetes as a disease process</p> <p><input type="checkbox"/> Prevent, detect, and treat chronic complications</p>
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MEDICAL NUTRITIONAL THERAPY (MNT)

Complete for Medicare only
Medicare: 3 hours initial MNT in the first calendar year, plus 2 follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment, and/or diagnosis. **

<input type="checkbox"/> Initial MNT	<input type="checkbox"/> Annual follow-up MNT
<input type="checkbox"/> 3 hours	<input type="checkbox"/> 2 hours
<input type="checkbox"/> _____ # hours	<input type="checkbox"/> _____ # hours
<input type="checkbox"/> Additional MNT service in the same calendar year	
<input type="checkbox"/> _____ # hours requested	**Please specify change in medical condition, treatment and/or diagnosis:

CURRENT DIABETES MEDICATIONS <i>Specify type, dose and frequency</i>
Oral:
Insulin (type and dose):

MISCELLANEOUS:
<input type="checkbox"/> Behavioral Health Consultation -- <input type="checkbox"/> Individual <input type="checkbox"/> Family
<input type="checkbox"/> Weight Management
<input type="checkbox"/> Start non-insulin injectable: (drug name) _____
<input type="checkbox"/> IGT (random glucose 141-199)
<input type="checkbox"/> IFG (fasting glucose 100-125)
<input type="checkbox"/> Continuous Subq Glucose Sensor (choose one): <input type="checkbox"/> Professional <input type="checkbox"/> Personal

Insulin/Insulin Pump Training
<input type="checkbox"/> Already on Insulin
<input type="checkbox"/> New Insulin Start
<input type="checkbox"/> Insulin Pump Training
<input type="checkbox"/> New pump <input type="checkbox"/> Pump upgrade <input type="checkbox"/> Pump review

ADDITIONAL ORDERS:

I certify that I am managing this patient's condition and DSMT and/or MNT are medically necessary and the education plan recommended by HDC will be communicated in progress notes to me. Insulin initiation, adjustments and CGMS can be used according to HDC protocol.

PHYSICIAN SIGNATURE:	NPI #:	DATE:	TIME:
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