

*\*Indicates required information*

**All orders MUST include a copy of the most recent visit note, lab results, vitals and medication list.**  
**Fax completed form to Diabetes Services at 920-623-1250. We will call your patient to schedule the education sessions.**

\*Patient's Name \_\_\_\_\_ \*DOB \_\_\_\_\_

\*Address \_\_\_\_\_

\*Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other Contact Phone \_\_\_\_\_

\*Patient's Health Insurance \_\_\_\_\_ ID# \_\_\_\_\_

**\*DIAGNOSIS (check ONE diagnosis)**

**Type 2 Diabetes**

- E11.9 Type 2 diabetes mellitus without complication
- E11.8 Type 2 diabetes with unspecified complications
- E11.65 Type 2 diabetes mellitus with hyperglycemia
- E11.40 Type 2 diabetes mellitus with diabetic neuropathy, unspecified
- E11.649 Type 2 diabetes mellitus with hypoglycemia without coma
- E11.21 Type 2 diabetes mellitus with diabetic nephropathy
- E11.59 Type 2 diabetes mellitus with other circulatory complications

**Gestational Diabetes**

- O24.41 Gestational diabetes mellitus in pregnancy

**Type 1 Diabetes**

- E10.9 Type 1 diabetes mellitus without complication
- E10.8 Type 1 diabetes with unspecified complication
- E10.65 Type 1 diabetes mellitus with hyperglycemia
- E10.40 Type 1 diabetes mellitus with diabetic neuropathy, unspecified
- E10.649 Type 1 diabetes with hypoglycemia without coma

**Other (must include written diagnosis description)**

- \_\_\_\_\_
- \_\_\_\_\_

**\*MODIFIER (check ONE modifier for type 1 or type 2 diabetes diagnoses)**

**Insulin/Medication Status Modifier**

- Z79.4 Long term (current) use of insulin
- Without insulin use
- Z79.84 Long-term (current) use of oral antidiabetic drugs

**\*REQUESTED EDUCATION/TRAINING** Coverage for requested services varies by insurance.

- Initial Diabetes Self-Management Education/Training (Medicare Coverage: 10 hrs initial DSME/T in 12 month period from the date of first class or visit) with Medical Nutrition Therapy (Medicare Coverage: 3 hrs initial MNT in the first calendar year).
- Annual Follow Up Diabetes Self-Management Education/Training (Medicare Coverage: 2 hrs).
- Annual Follow Up Medical Nutrition Therapy (Medicare Coverage: 2 hrs).
- Continuous Glucose Monitoring (professional/personal): sensor placement, hook-up, patient training, removal of sensor and data report.

Individual Education/Training Session(s)--**Check all that apply**

- Vision impairment
- Hearing impairment
- Physical limitations
- Language limitations
- Cognitive impairment
- Individualized insulin training
- Other: No group session available within 2 months.

**ADDITIONAL ORDERS**

- Diabetes Mellitus Medication Titration per Standing Order/facility treatment guidelines: Yes, HCP has authorized the use of the Standing Order/facility treatment guidelines per this referral. Diabetes educators with prescriptive authority may adjust or add diabetes medications, order labs, and supplies to achieve glycemic control.
- Insulin pump evaluation, initiation, insulin settings adjustments and follow-up.
- Determine insulin-to-carbohydrate ratio with correction factor and instruct patient on use.
- Other: \_\_\_\_\_

**\*PLAN OF CARE**

- Diabetes Services Staff to assess patient's knowledge and provide education as needed. Content areas (per guidelines for an ADA recognized program): Describing the diabetes disease process and treatment options, incorporating nutritional management into lifestyle, incorporating physical activity into lifestyle, using medication(s) safely and for maximum therapeutic effectiveness, monitoring blood glucose and other parameters and interpreting and using the results for self-management decision making, preventing, detecting, and treating acute complications, preventing detecting, and treating chronic complications, developing personal strategies to address psychosocial issues and concerns, developing personal strategies to promote health and behavior change.

**\*CERTIFICATION STATEMENT**

- I certify Diabetes Self-Management Education/Training and Medical Nutrition Therapy are needed under a comprehensive plan for this patient's diabetes care.

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Physician Name and UPIN#—Please Print \_\_\_\_\_

Office Contact name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_