Diabetes Age Well Program

Piedmont Triad Regional Council
1398 Carrollton Crossing Drive, Kernersville, NC 27284
P: (336)904-0300 Fax: (336)904-0361

ORDER FORM: DIABETES SELF-MANAGEMENT TRAINING (DSMT) AND MEDICAL NUTRITION THERAPY (MNT)

PLEASE FAX COMPLETED ORDER to: Laura Plunkett at 336-904-0361

PATIENT DATA:

Patient's First Name: _____Jane_____ Middle Initial: ___A____ Last Name:_____Doe_____

Preferred Phone: ____336-999-9999_____

Address: ___1 Circle Way_____Street ___Yanceyville_____ City ___NC__ State ___27379___ Zip Code

Date of Birth: __01____ / ___01_____ / ___1950_____

➢ Insurance type: _____Medicare_____

SERVICES TO BE PERFORMED

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.

___X_Initial DSMT and Initial MNT (10 + 3 Hours; Medicare benefits)

DSMT Content: √ Monitoring diabetes √ Psychological adjustment √ Nutritional management √ Medication √Goal Setting & Problem-Solving √Diabetes as disease process √Chronic Complications ☐ Preconception/Pregnancy/GDM

____Initial DSMT only

DSMT topics taught as needed as 1 hour individual + 9 hours **group** UNLESS **Special Need** checked below, then all **individual**.

Special Need: ☐ Vision ☐ Non-Ambulatory ☐ Physical disability ☐ Hearing ☐ Cognitive ☐ Language ☐ Other:_____

____Initial MNT only

____Additional MNT ➢ No. of extra hours =_____ Specify change in medical condition, treatment or dx:_____

____ Subsequent Year DSMT

____ Subsequent Year MNT

➢ **MEDICARE LAB ELIGIBILITY:**

➢ DSMT and diabetes MNT**:**

- FBG ≥126 mg/dl on 2 tests: FBG:____132_____ and FBG:_____129_____
- 2 hr OGTT ≥200 mg/dl on 2 tests: 2 hr OGTT:__205_____ and 2 hr OGTT:____220_____
- Random BG ≥200 mg/dl with symptoms of uncontrolled diabetes: Random BG:_____211_____ √ excessive thirst ☐ excessive urination ☐ excessive hunger ☐ blurry vision ☐ excessive tiredness √ unintentional wt loss ☐ tingling in extremities ☐ other:_____

Renal MNT: GFR 13 to 50 GFR:_____

➢ ***Please send labs to document patient eligibility and confirm diabetes diagnosis.***

➢ **OTHER LABS**: A1C:__8.5___ T-Chol____ LDL-C:_____ HDL-C:_____ TG:_____ BP: _159/100____ BMI:_____
Other:_____

➢ **DIAGNOSIS:** ☐ Type 1 √ Type 2

➢ Diagnosis code: _____E11.40_____ (5 character code required)

PROVIDER DATA:

Physician Name: _____Dr. John Smith_____

Address:_____1 Medical Center Way_____

➢ NPI: ____9999999999_____ Phone: __336-888-8888_____ Fax: __336-888-7777_____

➢ Signature: _____Print or Electronic_____ ➢ Date**:** __01___/ ___01____/ ___2018_____