

FAX FORM and RECENT LABS to 808-450-2399 and GIVE COPY TO PATIENT

Patient Information:

Patient's Last Name _____		First Name _____		Middle _____
Date of Birth: ____/____/____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Address _____		City _____	State _____	Zip Code _____
Home Phone _____		Other Phone _____		E-Mail Address _____

★Diabetes Self-Management Training (DSMT)★

☐ Initial Group DSMT –includes individual assessment and goal setting

☐ Initial Individual DSMT

Check special needs (Learning Barriers) supporting need for individual training:

- | | |
|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Language | <input type="checkbox"/> Physical |
| <input type="checkbox"/> Cognitive | Other _____ |

Note: Initial DSMT includes all content areas (10 hrs.) below (per pt. need), unless only specific areas or hours are requested here:

- ☐ Disease process
- ☐ SMBG/Monitoring
- ☐ Physical activity
- ☐ Medications
- ☐ Nutrition
- ☐ Goal setting/Problem solving
- ☐ Acute complications
- ☐ Chronic complications
- ☐ Psychosocial adjustment
- ☐ _____ Hours

☐ Annual Follow-Up DSMT (pt. previously attended initial DSMT)

★Medical Nutrition Therapy (MNT)★ –Both DSMT and MNT can be ordered, as both prove to improve outcomes.

☐ Initial MNT

☐ Annual Follow-Up

☐ Additional _____ # hours due to: ☐ Δ in medication ☐ Δ in medical condition ☐ lack of understanding diet

★Additional Services★

- ☐ inControl Diabetes Support Services (iDSS)
- ☐ Blood Glucose Monitoring Training (fax copy of RX)
- ☐ Injection Initiation and Training (fax copy of RX)
- ☐ Insulin Dose Titration/Adjustment
 - Intensive Insulin TX (Insulin to CHO Ratio & Correction)
- ☐ Insulin Pump Assessment/Training
- ☐ Continuous Glucose Monitoring (CGM) Training

DIAGNOSIS (Required for ALL services)

Type 1	Type 2	PreDM
<input type="checkbox"/> E10.9	<input type="checkbox"/> E11.9	<input type="checkbox"/> R73.01
<input type="checkbox"/> E10.65	<input type="checkbox"/> E11.65	<input type="checkbox"/> R73.02
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____

Complications/Comorbidities

- | | |
|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> HTN | <input type="checkbox"/> Dyslipidemia |
| <input type="checkbox"/> CKD | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> CVD | <input type="checkbox"/> Retinopathy |
| <input type="checkbox"/> Other _____ | |

MEDICARE PTs ONLY: Medicare coverage of DSMT and MNT requires documentation of a diagnosis of diabetes based on one of the following: (Check one)

- ☐ FPG ≥ 126 mg/dl (x2 occasions); or ☐ 2 hour OGTT ≥ 200 mg/dl (x2 occasions); or ☐ Random > 200 mg/dl + symptoms

Source: Volume 68, #216, November 7, 2003, page 63261/Federal Register

Physician Name: _____

Address: _____

NPI # (Required): _____

Appointment scheduled: _____ Signature: _____ Date: ____/____/____