DIABETES and NUTRITION EDUCATION SERVICES ORDER FORM

inControl Diabetes Learning and Resource Center • 1449-A S. Beretania St. • Honolulu, HI 96814
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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: □ Male □ 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:

□ Hearing □ Vision
□ Language □ Physical
□ 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
□ E10.9	□ E11.9	□ R73.01
□ E10.65	□ E11.65	□ R73.02
□ _____	□ _____	□ _____

Complications/Comorbidities

□ HTN □ Dyslipidemia
□ CKD □ Neuropathy
□ CVD □ Retinopathy
□ 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

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Physician Name:
Address:
NPI # (Required):
Appointment scheduled: _____ Signature:_____ Date: ____/____/____