Hartford HealthCare

Diabetes Self-Management Education/Training and Medical Nutrition Therapy Services Order Form

Patient name: _____ **DOB:** _____ **Gender** ☐ Male ☐ Female

Street Address: _____ **Town:** _____ **State/Zip:** _____

Phone: _____ **Insurance:** _____ **Policy#:** _____

Diabetes Diagnosis

☐ Type 1, controlled ☐ Type 1, uncontrolled ☐ Type 2, controlled ☐ Type 2, uncontrolled

☐ Gestational ☐ Pre-Existing DM with Pregnancy

Indicate one or more reason for referral:

☐ Newly Diagnosed
☐ Device Training
☐ Recurrent elevated blood glucose levels
☐ Recurrent Hypoglycemia
☐ Change in DM treatment regimen
☐ High risk due to Diabetes Complications/Co-morbid conditions

☐ Retinopathy ☐ Neuropathy ☐ Gastroparesis ☐ Cardiovascular disease
☐ Hypertension ☐ Nephropathy ☐ Hyperlipidemia ☐ Other: _____

Please send most recent labs, patient note, and any relevant medical history

****Indicate any existing barriers to group learning requiring customized education or additional training requiring 1:1 education**

☐ Impaired Mobility ☐ Impaired Dexterity ☐ Impaired Mental Status/Cognition
☐ Impaired Hearing ☐ Language Barrier ☐ Self Blood Glucose Monitoring
☐ Impaired Vision ☐ Eating Disorder ☐ Learning Disability
☐ Change in Medication ☐ Insulin Training ☐ Other:
☐ Social Distancing during Pandemic

Referral For: Diabetes Self-Management Training (DSMT)

☐ Initial Comprehensive Diabetes Self-Management Training (DSMT) - 10 hours and topics checked below or # of hours: _____

☐ Gestational Diabetes Self-Management Training
☐ DSMT: Follow-up - 2 hours or # of hours: _____
☐ Specific Topics and Hours if needs vary from above: _____

***DSMT can be order by an MD,DO or midlevel provider managing the patient's diabetes**

Check specific topics to be covered:

☐ **All content areas**

☐ Diabetes as a disease process
☐ Monitoring Diabetes
☐ Prevent, detect and treat acute complications
☐ Prevent, detect and treat chronic complications
☐ Preconception and Pregnancy Management
☐ Healthy Eating
☐ Physical Activity
☐ Medications
☐ Psychological Adjustment
☐ Goal Setting and problem solving

☐ I hereby certify that I am managing this beneficiary's diabetes condition and that the above prescribed training is a necessary part of management. (Medicare Patients)

Referral for: Medical Nutrition Therapy

☐ Medical Nutrition Therapy (MNT) initial - 3 hours *** MNT must be order by and MD or DO**
☐ MNT: Follow-up - 2 hours

Physician Signature (Required): _____ **Date and time:** _____
(Stamped signatures are not accepted)
Physician Name (Printed): _____