Rockwood Diabetes and Endocrinology Center fax to: 509-342-3475
Diabetes Services Order Form (DSMT and MNT Services)

*Indicates **required** information for Medicare order

Patient's Last Name First Name Middle

Date of Birth ___/___/___ Medicare HICN # _____ Gender ___ Male ___ Female

Address City State Zip Code

Home Phone Work Phone Other Contact Phone

Recommend ordering DSMT and MNT concurrently to avoid having to submit second referral for patients who are being seen individually for education.

DIABETES SELF-MANAGEMENT TRAINING (DSMT)

Medicare: 10 hours initial DSMT in 12-month period, plus 2 hours follow-up DSMT annually

**Check type of training services and number of hours requested:*

- ☐ Initial group DSMT: ☐ 10 hours or ___ no. hrs. requested
- ☐ Follow-up DSMT: ☐ 2 hours or ___ no. hrs. requested
- ☐ Additional insulin training: ___ no. hrs. requested

*** Patients with special needs requiring individual DSMT**

Check all special needs that apply:

- ☐ Vision ☐ Hearing ☐ Physical ☐ Cognitive Impairment
- ☐ Language Limitations ☐ Other _____

*** DSMT Content**

- ☐ All ten content areas, as appropriate
- ☐ Monitoring diabetes
- ☐ Psychological adjustment
- ☐ Nutritional management
- ☐ Medications
- ☐ Preconception/pregnancy management or gestational diabetes management
- ☐ Diabetes as disease process
- ☐ Physical activity
- ☐ Goal setting, problem solving
- ☐ Prevent, detect and treat acute complications
- ☐ Prevent, detect and treat chronic complications

* DIAGNOSIS

Please send recent labs for patient eligibility & outcomes monitoring

- ☐ Type 1 uncontrolled
- ☐ Type 2 uncontrolled
- ☐ Gestational diabetes
- ☐ Type 1 controlled
- ☐ Type 2 controlled
- ☐ Other _____

Complications/Comorbidities

Check all that apply:

- ☐ Hypertension
- ☐ Neuropathy
- ☐ Renal disease
- ☐ Non-healing wound
- ☐ Mental/affective disorder
- ☐ Dyslipidemia
- ☐ Nephropathy
- ☐ Retinopathy
- ☐ Pregnancy
- ☐ Other _____
- ☐ Stroke
- ☐ PVD
- ☐ CHD
- ☐ Obesity

MEDICAL NUTRITION THERAPY (MNT)

Medicare: 3 hours initial MNT in the first calendar year, plus two hours follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis.

** Check the type of MNT and/or number of additional hours requested:*

- ☐ Initial MNT ☐ Annual follow-up MNT
- ☐ Additional MNT services in the same calendar year, per RD recommendations ___ no. additional hrs. requested

Please specify change in medical condition, treatment and/or diagnosis:

CURRENT DIABETES MEDICATIONS

Specify type, dose and frequency

Oral:

Insulin:

Patient now uses: ☐ Pen ☐ Needle ☐ Pump

PATIENT BEHAVIOR GOALS/PLAN OF CARE

*Signature and UPIN # _____ *Date ___/___/___

Group/practice name, address and phone: _____