Sentara
400 Sentara Circle, Suite 203
Williamsburg, VA 23188
757-984-7106 (Direct Line)

Patient Label

SWRMC ONLY
Diabetes & Nutrition Management Education Order

MDORD

Today's Date: _____ ****Please Fax To: 757-984-7109** (Attach any pertinent lab work)**

Patient Name_____ DOB _____

Phone(H)_____(M)_____(W)_____

Preferred Email_____

Insurance Name _____

ID # _____Group#_____

Patient's Preferred Day/Time ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Mornings 8–11 a.m. ☐ Midday 1–3 p.m. ☐ Afternoons 3–5 p.m.

FOR DIABETES DIAGNOSIS:

☐ Type 1 (E10.9)
☐ Type 1 (uncontrolled) (E10.65)
☐ Type 2 (E11.9)
☐ Type 2 (uncontrolled) (E11.65)
☐ Gestational (O24.419)
☐ Gestational – Abnormal glucose (O99.810)
☐ Diabetes with Pregnancy – 1st Trimester (O24.911)
☐ Diabetes with Pregnancy – 2nd Trimester (O24.912)
☐ Diabetes with Pregnancy – 3rd Trimester (O24.913)
☐ Pre-Diabetes (R73.01)
☐ Other _____

HgbA1c _____ Serum Creatinine _____ FBG_____ CHOL _____

HDL _____ LDL _____ TRIGLYCERIDES_____ Height _____Weight _____

Diabetes Medications _____

Other Medications_____

Outpatient Reimbursement Criteria (For Insurance Reimbursement): The criteria below has been developed as a guideline to validate the need for supplemental diabetes self-management training above and beyond the usual, reasonable, and necessary training provided by the physician.

Mark One or More of the Following Reasons for Patient Referral.

A. ☐ New onset diabetes
☐ Recurrent elevated blood glucose (fasting glucose > 126 mg/dL, recurrent random glucose >200 mg/dL; or HgbA1c>6.5)
☐ Recurrent hypoglycemia or hyperglycemia unawareness.
☐ Recent hospitalization for DKA or HHNK indicating need for supplemental diabetes self management training.
☐ Recurrent utilization of diabetes services via emergency room, hospital, home health services, physician office or clinic visit.
☐ Non-compliance to recommended regimen.
☐ Other:_____

B. Existing barriers that impede the patient's ability to obtain diabetes self-management skills through routine physician office training or group sessions:
☐ Learning Disability ☐ Visual Impairment ☐ Special Communication Need ☐ Other _____
☐ Impaired Dexterity ☐ Impaired Hearing ☐ Low Literacy

GROUP EDUCATION ***(choose one)***

☐ **Healthy Living with Diabetes:** Comprehensive Group Program-9 hrs. of class includes: Individual Assessment, Understanding Diabetes/Complications/ Foot Care/Community Resources/Nutrition Mgmnt/Changing Habits/Sick Day Mgmnt/Medication/Monitoring/Exercise/Stress/Goal Setting

☐ **Gestational Diabetes Management:** 2 hour class includes: diabetes and pregnancy, monitoring/meter, physical activity, individualized meal plan; individual follow up as needed.

☐ **Pre-Diabetes Prevention Program:** 1 year program: Class includes nutrition, physical activity, weight management, goal setting, and glucose monitoring instruction. Classes are currently being offered at SVBGH and SPAH.

INDIVIDUAL SESSIONS ***(check all that apply)***

☐ **Diabetes Self-Management Training and Support:** up to 2 hour initial, individual follow up as needed

☐ **Insulin Start:** up to 2 hour instruction regarding preparation, self-injection, prevention & treatment of low & high blood sugar, basic carbohydrate counting and meal planning
Insulin Type: _____**Dose:**_____**Frequency:**_____

☐ **Intensive Insulin Management/Adjustment:** includes advanced carbohydrate counting and insulin adjustment training

☐ **Insulin Pump Education and Management:** _____

☐ **Nutrition Counseling/Medical Nutrition Therapy** ***(special needs related to diabetes)*****:**
Examples: Renal, Gastroparesis, etc. **SPECIFY:**_____

NOTE: PLEASE INITIATE THE PROCESS OF PRIOR AUTHORIZATION FOR THE ABOVE REQUEST, IF SPECIFIED AND REQUIRED BY THE CLIENT'S INSURER(S). THANK YOU

Physician Signature_____

Physician Name ***(please print or stamp)*** _____

Date/Time_____

ADCES DEAP DIABETES EDUCATION ACCREDITATION PROGRAM