

Patient Label



I am referring:
 Patient Name _____ DOB _____ SS# _____
 Address _____
 Phone: (H) _____ (C) _____ (W) _____
 Weight _____ Height _____
 Insurance Name _____ Authorization # _____ Number of Visits _____
 Visit Start & End dates _____
 For the necessary Diabetes out-patient self-management program:
 Diabetes Diagnosis: Type 1 Type 2 IGT Gestational Other _____
 Recent HgbA1c: _____ Date: _____ (Attach any pertinent lab work)
 Blood Glucose Target Range: _____

GROUP EDUCATION

- Health Living with Diabetes:** Comprehensive Group program – 10 hours of class includes: Individual Assessment, Understanding Diabetes / Complications / Foot Care / Community Resources / Nutrition Management / Changing Habits / Sick Day Management / Medication / Monitoring / Exercise / Stress / Goal Setting
- Gestational Diabetes Management:** Comprehensive Group program – 3 hours of class includes: Diabetes and Pregnancy, Monitoring/Meter, Record Keeping, Individualized Meal Plan

INDIVIDUAL SESSIONS

- Diabetes Self-Management Training:** (2 Hours, with two 30 min follow-up sessions, as needed) Includes Basic Carbohydrate Counting
- Insulin Start:** (2 Hours) Preparation / Self Injection / Prevention / Treatment of Low / High Blood Sugar, Basic Carbohydrate counting and meal planning
 Insulin type: _____ Dose: _____ Frequency: _____
- Use of Blood Glucose Meter:** (1 hour) Operation of Meter, Obtaining Sample of Capillary Blood, Record Keeping
- Nutrition Counseling / Medical Nutrition Therapy** (1.5 hours) (special needs related to diabetes): Examples: Renal, Gastroparesis, etc.
 Specify Code(s): _____
- Intensive Management** (2 Hours with two 30 min follow sessions as needed)
 Includes Advanced Carbohydrate Counting & Insulin Adjustment Training

Physician Signature _____ Date/Time _____
 Physician Name – please print _____
 Address _____ Tel # _____ Fax # _____

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. Poorly Controlled Diabetes or 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. Diabetes Complications

<input type="checkbox"/> Retinopathy	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Nephropathy
<input type="checkbox"/> Dermatomopathy	<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Cardiovascular Disease
<input type="checkbox"/> Other _____			
- C. Existing barriers that impede the patient's ability to obtain diabetes self-management skills through routine physician office training:

<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Visual Impairment	<input type="checkbox"/> Impaired Psychosocial Status	<input type="checkbox"/> Impaired Dexterity
<input type="checkbox"/> Impaired Mobility	<input type="checkbox"/> Morbid Obesity	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Low Literacy
<input type="checkbox"/> Impaired Hearing			
<input type="checkbox"/> Other _____			

For reimbursement purposes, it is preferred to elaborate on the specific values, severity, and time frames related to any of the above.