SENTARA®
eCare Health Network

Patient Label

SWRMC ONLY
Diabetes and Nutrition Outpatient Center
Diabetes Education Order

****Please Fax to (757) 984-7109****

I am referring:
Patient Name ______________________________ DOB ______________
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

☐ **Insulin Pump Therapy** (3 visits / 6 hours)
Pump Selection/Video Presentations, Pump Operation Training, Carbohydrate Counting, Intensive Management, Trial Pumping Normal Saline

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

☐ Retinopathy	☐ Neuropathy	☐ Pregnancy	☐ Nephropathy
☐ Dermatopathy	☐ Hyperlipidemia	☐ Hypertension	☐ Cardiovascular Disease
☐ Other ______________			

C. Existing barriers that impede the patient's ability to obtain diabetes self-management skills through routine physician office training:

☐ Learning Disability	☐ Visual Impairment	☐ Impaired Psychosocial Status	☐ Impaired Dexterity
☐ Impaired Mobility	☐ Morbid Obesity	☐ Eating Disorders	☐ Low Literacy
☐ Impaired Hearing		☐ Other ______________	

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

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

DEAP
Diabetes Education Accreditation Program
AADE American Association of Diabetes Educators

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