SENTARA
eCare Health Network

Patient Label

SCH ONLY
Diabetes Outpatient Department
Diabetes Education Order

MDORD

****Please Fax to (757) 827-2173****

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 ☐ Other _____
Diagnosis Code: _____
Recent HgbA1c: _____ Date: _____ (Attach any pertinent lab work)
Blood Glucose Target Range:_____

GROUP EDUCATION

☐ **Health Living with Diabetes**: Comprehensive Group program – 9 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

☐ Sentara CarePlex Campus ☐ Sentara Port Warwick Campus

INDIVIDUAL SESSIONS

☐ **Insulin Start/Injectables**: Preparation / Self Injection / Prevention / Treatment of Low / High Blood Sugar
Insulin type: _____ Dose: _____ Frequency: _____

☐ **Use of Blood Glucose Meter**: Operation of Meter, Obtaining Sample of Capillary Blood, Record Keeping, Meal Plan

☐ **Medical Nutrition Therapy** (special needs related to diabetes)
Specify Code(s): _____

☐ **Intensive Management**
Includes Advanced Carbohydrate Counting & Insulin Adjustment Training

☐ **Insulin Pump Therapy**
Pump Selection/ Video Presentations, Pump Operation Training, Carbohydrate Counting, Intensive Management

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.

Scheduled Appointment:
Date: _____ Time: _____ Scheduled by: _____
Dates of contact: 1. _____ 2. _____ 3. _____

DEAP
Diabetes Education Accreditation Program
AADE American Association of Diabetes Educators

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