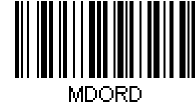
SENTARA
eCare Health Network

Patient Label

SVBGH ONLY
Diabetes Outpatient Center
Diabetes Education Order



****Please Fax to (757) 395-8626****

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

INDIVIDUAL SESSIONS

☐ **Insulin Start:** 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 Treatment of Low / High Blood Glucose

☐ **Gestational Diabetes Management:** Diabetes and Pregnancy, Monitoring / Meter, Record Keeping, Individualized Meal Plan

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

☐ **Advanced Carbohydrate Counting** (1 ½ Hours)

☐ **Intensive Managem3ent** (2 Hours)
Includes 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