



2800 Godwin Blvd
Suffolk, VA 23434
757-934-4879 (Direct Line)

Patient Label

SOH ONLY
Diabetes & Nutrition
Management Education Order



MDORD

Today's Date: _____ **Please Fax To: 757-934-4536**** (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) ☐ Gestational (O24.419) ☐ Diabetes with Pregnancy – 3rd Trimester (O24.913)
☐ Type 1 (uncontrolled) (E10.65) ☐ Gestational – Abnormal glucose (O99.810) ☐ Pre-Diabetes (R73.01)
☐ Type 2 (E11.9) ☐ Diabetes with Pregnancy – 1st Trimester (O24.911) ☐ Other _____
☐ Type 2 (uncontrolled) (E11.65) ☐ Diabetes with Pregnancy – 2nd Trimester (O24.912)

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 Mgmt/Changing Habits/Sick Day Mgmt/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 _____



MDORD501 Reviewed 8/2021, 7/2023