ADA #003542 Standard 5

Diabetes Self-Management Education and Support / Training Referral Form

Website: www.DiabetesFL.com Tel: 941- 624-4800 **Fax: 941-206-0048**

From:	Provider Tel: (941)
Provider NPI:	Provider Fax: (941)

Referral Type: Diabetes Self-Management Education and Support Training (DSMES/T)

CONTENT AREAS: Comprehensive program includes education on diabetes basics, Healthy Eating, Being Active, Taking Medications, Monitoring Glucose, Prevention, detection and Treatment Acute Complications, Prevention, Detection and Treatment chronic complications, Lifestyle and Healthy Coping, Diabetes Distress and Support, Problem solving as appropriate, interactive discussion.

PATIENT CONTACT INFORMATION

Name:	**DOB:**
Telephone:	**Email:**
Insurance: ☐ Medicare ☐ Commercial ☐ Self Pay **Forward us copy of both sides of patient's insurance card or your EMR demographics page**	

	CHOOSE ONE ITEM
Group Training Ordered / Requested plan of care	☐ Initial Program (10 hours in a group G0109 or individual setting G0108 if with impairment) conducted over a 12-month period. ☐ Annual Training (2 hours in a group setting provided once during a calendar year). Patient had prior training. Optional Provider specific request. **These topics are part of Initial program.** ☐ Self-blood glucose monitoring ☐ Insulin, CGM and / or pump instruction ☐ Education on diet & meal planning and exercise ☐ 3hrs or _____hours
Individual Training due to impairment	***Please check all impairments that apply to document reason for individual training*** ☐ Vision ☐ Hearing loss ☐ Cognitive impairment ☐ Language ☐ Physical disability

Please fax back this referral along with below bolded labs

Select all that apply Diagnosis *(Reason for Training)*	☐ Type 2 Diabetes ☐ Type 1 Diabetes ☐ Established ☐ New (less than 1 year) **(Diagnosis: FBS ≥ 126 mg/dl x 2 or random glucose >200mg/dl x 1 with symptoms)** Below condition must occur within 12 months before training ☐ Inadequate glycemic control A1c>8.5% x 2 ☐ Severe hypoglycemia ☐ Recent diabetes related hospitalization ☐ Microvascular complications ☐ Change in medical condition, diabetes treatment and/or diagnosis State change in condition or treatment plan _____
Complications /Co-morbidities	*Please check all that apply if any (needed for accurate coding)* ☐ Kidney disease ☐ Neuropathy ☐ Retinopathy ☐ Carotid artery disease ☐ Gastroparesis ☐ Heart Disease ☐ Hyperlipidemia ☐ Hypertension ☐ Obesity ☐ PVD ☐ Stroke ☐ None

I am the healthcare provider treating this patient for diabetes. DSMES/T is necessary to provide this patient with the knowledge and skills necessary to better manage their diabetes.

Provider Signature _____ **Date:** _____

MD/DO/ARNP/PA-C E-signature allowed. NO STAMPED SIGNATURE