UCONN HEALTH

Diabetes Education Program

(Patient Identification)

Diabetes Education Referral/Order Form

Patient Name _____ DOB _____

Address _____

Phone: Home _____ Work _____ Cell _____

Insurance Plan:_____

Please send a copy of most recent office visit note, labs and medication list.

Diabetes is diagnosed at an A1C of greater than or equal to 6.5%, fasting blood glucose of greater than or equal to 126 mg/dl, OGTT two-hour blood glucose of greater than or equal to 200 mg/dl, random glucose of greater than or equal to 200 mg/dl while symptomatic.

Pertinent Diagnosis:

☐ Type 1 Diabetes, Controlled (E10.9) ☐ Type 2 Diabetes, Controlled (E11.9)

☐ Type 1 Diabetes, Uncontrolled (E10.65) ☐ Type 2 Diabetes, Uncontrolled (E11.65)

☐ Gestational Diabetes (024.419, 099.810) ☐ Other:_____

☐ Pregnancy complicated by preexisting DM (024.911, 024.912, 024.913)

☐ Pre-diabetes (R73.09): (Inform your patients that not all insurance carriers cover medical nutrition therapy or lifestyle modification treatments for pre-diabetes. Encourage your patients to take proactive steps by calling their insurance carrier to verify coverage)

Medicare allows:

Diabetes Self-Management Training (DSMT)	**Medical Nutrition Therapy (MNT)**
1. 10 hours of DSMT completed in a 12 month period as a one time benefit **2**. Plus 2 hours follow up annually thereafter (DSMT requires a DX of DM and must be ordered by the provider who is managing the patient's diabetes)	**1**. 3 hours of MNT for the first calendar year as a one time benefit **2.** Plus 2 hours follow up annually thereafter. (MNT must be ordered **only** by physician MD/DO and requires a Dx of DM or CKD)

(Studies report that DSMT and MNT together are more effective than either service would be if offered alone.)

CHECK THE TYPE OF REFERRAL DESIRED BELOW

☐ **1. I have chosen the Plan of Care for DSMT, and/or MNT for my patient. Please check the box(es) for the type of referral desired from options below.**

OR

☐ **2. I recommend that the UConn Diabetes Education Program evaluates and chooses the plan of Care for my patient.**

- ☐ Initial Diabetes Self-Management Training (DSMT) - 10 hrs and all 9 topics of Self-Management
- ☐ DSMT: Follow up - 2 hrs
- ☐ Diabetes Self-Management Training/Followed by Medical Nutrition Therapy
- ☐ Medical Nutrition Therapy Initial - 3 hrs
- ☐ Medical Nutrition Therapy: Follow up - 2 hrs
- ☐ Diabetes Outpatient Self-Management, Group Classes (2 or more people)

HCH1623

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☐ **If needs Individual visit (for patient with special or specific needs, must check one of the needs below)**

☐ Impaired Vision ☐ Impaired Mobility ☐ Impaired Hearing ☐ Impaired Dexterity ☐ Learning Disability

☐ Language Barrier, Preferred Language_____ ☐ Mental/Psychosocial Issues

☐ Other (specify)_____

☐ Additional Orders: _____

☐ I have chosen the Plan of Care for DSMT, and/or MNT for my patient. Please check the box(es) for the type of referral desired (page 1) and complete the signature below.

I hereby certify that I am managing this beneficiary's Diabetes condition and that the above prescribed training is a necessary part of management (Medicare participants).

*Print Provider Name: _____Phone Number: _____

* Provider Signature: _____Date/Time_____ Fax Number: _____

Fax to: 860-679-1217

Mail to: UConn Health – Diabetes Education Program
UConn Health Outpatient Pavilion, Floor 2, East Wing
263 Farmington Avenue, Farmington, CT 06030-8025
Office: 860-679-3245

UConn Staff/Diabetes Education Office Use: Date/Time of Class/Appointment: _____

☐ Patient Did Not Show ☐ Rescheduled, Date/Time: _____ ☐ Patient Refused