

### 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 1 Diabetes, Uncontrolled (E10.65)
- Gestational Diabetes (024.419, 099.810)
- 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)
- Type 2 Diabetes, Controlled (E11.9)
- Type 2 Diabetes, Uncontrolled (E11.65)
- Other: \_\_\_\_\_

#### Medicare allows:

##### Diabetes Self-Management Training (DSMT)

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)

##### Medical Nutrition Therapy (MNT)

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

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**UConn Staff/Diabetes Education Office Use: Date/Time of Class/Appointment: \_\_\_\_\_**

- Patient Did Not Show     Rescheduled, Date/Time: \_\_\_\_\_     Patient Refused