Grundy County Memorial Hospital
UnityPoint Health

Fax form, labs, chart records to: (319) 824-5094
Call with questions: (319) 824-5081 or toll free (888) 824-5081

Ambulatory Referral to ADA Recognized Program for Diabetes Self-Management Training/Education

****Send recent labs and last chart note** for eligibility and outcomes measuring: **A1C,** Lipids, Microalbumin/ACR, OGTT, CBC, CMP

______________________________ ___/___/___ ______________________________
Patient Last Name **First Name** **Middle Initial** **DOB** **Insurance** write in or provide front/back copy of card(s)
Phone ________________ **Diagnosis (Fill in ICD-10 Code and Description)** __ __ __.__ __ Description: ______________________________

Exercise: ☐ Patient is medically cleared to exercise ☐ Exercise restrictions: ______________________________

Referral Reason(s): ☐ New diagnosis ☐ Gestational Diabetes ☐ Pregnancy & Diabetes ☐ Preconception ☐ Pre-DM ☐ At Risk for DM
☐ Annual Needs Assessment ☐ Hyperglycemia ☐ Hypoglycemia ☐ High risk for complications from diabetes ☐ New complicating factors
☐ Change in treatment ☐ Transitions in Care ☐ Surgical Clearance ☐ Other______________________________

Reason patient not able to learn in a group: ☐ **NA** ☐ Vision ☐ Physical ☐ Hearing ☐ Dexterity
☐ Cognitive/Memory ☐ Language ______________________Check if Interpreter Required:☐ ☐Other ______________________________

Comprehensive Diabetes Self-Management Training, Education & Support (DSMT)

Non-Medicare: ☐ Individual or Group DSMT provided based on coverage and patient's individualized need(s) *Coverage varies*

Medicare initially allows 10 hrs of education in a group within 12 months. 1 hr may be an individual visit. *A Medicare compliant reason must be indicated on referral if more than 1 hr will be individual instead of in a group.* *2 hrs/yr of follow-up education is then allowed in a group or individual format.*

☐ **Initial** 10hrs: ☐ **Group** ☐ **Individual:** *Must indicate reason (above) individual visits are required* ☐ **Follow-up** 2 hrs *can be group or individual*
Or ☐ Initial ____ hrs Or ☐ Follow-up ____ hrs

Medicare requires record of lab values to cover DSMT ***If patient has Medicare the following must be included with initial DSMT referral order:***

- Fasting blood glucose (BG) ≥ 126 mg/dl **on 2 separate occasions OR** Result #1 ___________ (date):___________ Result #2 ___________ (date):_________
- 2 hr post glucose challenge ≥ 200 mg/dl **on 2 separate occasions OR** OR Symptoms with Result ____________ (date):____________
- Random BG ≥ 200 mg/dl with symptoms of uncontrolled diabetes Symptoms ______________________________

Medicare does not accept A1C as valid diagnostic criteria

☐ **All Core Topics** covered in class &/or individually in comprehensive, follow-up/ annual, & 'Additional Services' diabetes education visits. Training Content (curriculum options) to be delivered per patient's individual need as assessed by Diabetes Educator.
OR Specify Content (***optional, not generally recommended*** *):* ☐ *Describe diabetes disease process and treatment options* ☐ *Develop strategies to promote health & behavior change*
☐ *Use medications safely & for maximum therapeutic effectiveness* ☐ *Incorporate physical activity into lifestyle* ☐ *Develop personal strategies to adress psychosocial concerns*
☐ *How to prevent, detect, & treat chronic complications* ☐ *How to prevent, detect, & treat acute complications* ☐ *Monitor, interpret, & use results for self-management decisions*
☐ *Incorporate nutritional management into lifestyle* ☐ *Other*______________________________

☐ **Diabetes Prevention Program (DPP):** Coverage varies. Pre-Diabetes education or Diabetes Prevention Program based on pt's diagnosis and program availability

DSMT and medical nutrition therapy (MNT) are individual and complementary services to improve diabetes care. Both services may be ordered in the same year.
Research indicates MNT combined with DSMT improves outcomes. Consider also referring for MNT using the MNT referral form.

As the physician or qulified practitioner, I hereby certify that I am managing this benficiary's diabetes condition and that the above prescribed training is a necessary part of the management plan to ensure therapy compliance and/or to provide the beneficiary with the skills and knowledge to manage the beneficiary's diabetes.

Signature *(No stamped signatures)* ______________________________**Time:** _________ **Date:** _____________ **Phone:** ______________________

Printed Provider Name ______________________________ **NPI:** ______________________________

Form #: 026-PO-GEN

Date: 12/2018