PUTNAM HOSPITAL CENTER
DIABETES SELF-MANAGEMENT PROGRAM/MNT REFERRAL FORM

NAME: _____**DOB:**_____**Date:**_____
ADDRESS:_____
HEALTH INSURANCE: _____**INSURANCE ID#**_____
PHONE: HOME #_____**CELL #**_____

Diagnosis:

☐ Type 1 DM E10.8 ☐ Type 1 DM E10.9 ☐ Type 2 DM E11.9 ☐ Type 2- DM E11.65
☐ Gestational diabetes O24.410 ☐ Gestational Diabetes Insulin controlled O24.414
☐ Pre-diabetes/IGT- R73.03 ☐ Impaired fasting BG- R73.01 ☐Long term/current insulin use Z79.4

OTHER CODES: _____Complications/Comorbidities: _____

Documentation of Medical Necessity:

☐ Newly Diagnosed with diabetes ☐ Blood glucose monitoring ☐ Continuous Glucose Monitoring
☐ Change in treatment regimen ☐ Elevated A1C ☐ Annual Assessment: Education, Nutrition, and Emotional Needs
☐ New to Oral Diabetes medication ☐ Unstable or poorly controlled Diabetes ☐ New to insulin
☐Long term/current insulin use ☐ High risk due to diabetes complications ☐ Other _____

Check the type of training services and number of hours requested:

☐ **Initial DSMES/T* - 10 hours** – (Medicare benefit) All 9 topics covered as needed **(**Disease process, SMBG, Nutrition, Physical Activity, Medications, Acute Complications/Problem Solving, Stress/coping, Chronic complications/Risk reduction, Promote Health Change behavior/Goal setting.**)**
Or only these topics: _____ # of hrs requested: _____

*DSMES/T can be ordered by a MD, DO or midlevel provider managing the participant's diabetes

☐ **Patients with special needs requiring individual 1:1 DSMES/T: Please check appropriate box below**
☐Vision ☐Hearing ☐Physical ☐Cognitive impairment ☐ Language ☐ Covid-19 Emergency Period

☐ **Initial MNT- Medical Nutritional Therapy** -** ☐ 3 hrs. Or _____ #hrs. Requested

**MNT must be ordered by MD or DO

☐ **Management of diabetes during pregnancy- # week Gestation_____ Estimated DOD: _____**

☐ **Subsequent year: DSMES/T –- 2 hrs.** (Medicare benefit)
☐ **Subsequent year**: **MNT–- 2 hrs.** (Medicare benefit)

☐ **I hereby certify that I am managing this beneficiary's Diabetes condition and that the above prescribed training is necessary part of management.**

Provider Signature: _____ **Provider Name:** _____
(S*ignature or telephone order acceptable do not stamp)*
Address:
Phone: **Fax:**

Fax signed form along with lab work (FBS/2Hr.OGTT, lipids, creatinine, HgbAIC, microalbumin)

Diabetes /Nutrition Program: Fax:845-278-5504 (Tel: 845 279-5711 ext. 2779)