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Diabetic Center
 AT THE MEDICAL PARK

525 N. Eastown Road
 Lima, OH 45807
 TEL. (419) 998-4699
 FAX (419) 998-4688
Call for an appointment

Patient's Last Name _____ First Name _____ Middle _____

Date of Birth ___/___/___ Medicare HICN # _____ Gender Male | Female

Address _____ City _____ State _____ Zip Code _____

Home Phone (____) _____ Work Phone (____) _____ Other Contact Phone (____) _____

Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) are individualized services provided to improve diabetes care. For Medicare beneficiaries, both services can be ordered in the same year. Research indicates MNT combined with DSMT improve outcomes.

Diabetes Self-Management Training (DSMT)	
Medicare: 10 hours initial DSMT in 12 month period, plus 2 hours follow-up DSMT annually	
<i>* Check type of training services and number of hours requested:</i>	
<input type="checkbox"/> Initial group DSMT:	<input type="checkbox"/> 10 Hours or ___ no. hrs. requested
<input type="checkbox"/> Follow up DSMT:	<input type="checkbox"/> 2 hours or ___ no. hrs. requested
<input type="checkbox"/> Additional insulin training	___ no. hrs. requested
Patients with special needs requiring individual DSMT	
<i>* Check all special needs that apply:</i>	
<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing
<input type="checkbox"/> Language Limitations	<input type="checkbox"/> Physical
	<input type="checkbox"/> Cognitive Impairment
	<input type="checkbox"/> Other _____
*DSMT Content	
<input type="checkbox"/> All ten content areas as appropriate	<input type="checkbox"/> Diabetes as disease process
<input type="checkbox"/> Monitoring Diabetes	<input type="checkbox"/> Physical activity
<input type="checkbox"/> Psychological adjustment	<input type="checkbox"/> Goal setting, problem solving
<input type="checkbox"/> Nutritional management	<input type="checkbox"/> Prevent, detect and treat acute complications
<input type="checkbox"/> Medications	<input type="checkbox"/> Prevent, detect and treat chronic complications
<input type="checkbox"/> Preconception/pregnancy management or gestational diabetes management	
Diagnosis	
<i>Please send recent labs for patient eligibility & outcomes monitoring</i> Lipid Profile, Hgb A1C, CMP, UA, Microalbuminuria	
<input type="checkbox"/> Type 1 uncontrolled	<input type="checkbox"/> Type 1 controlled
<input type="checkbox"/> Type 2 uncontrolled	<input type="checkbox"/> Type 2 controlled
<input type="checkbox"/> Gestational diabetes	<input type="checkbox"/> Other
Complications/Comorbidities	
<i>Check all that apply</i>	
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Dyslipidemia
<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Nephropathy
<input type="checkbox"/> Renal disease	<input type="checkbox"/> Retinopathy
<input type="checkbox"/> Non-healing wound	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Mental/affective disorder	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Stroke
	<input type="checkbox"/> PVD
	<input type="checkbox"/> CHD
	<input type="checkbox"/> Obesity

Medical Nutrition Therapy (MNT)
Medicare: 3 hours initial MNT in the first calendar year, plus 2 hours follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis.
<i>*Check the type of MNT and/or number of additional hours requested:</i>
<input type="checkbox"/> Initial MNT
<input type="checkbox"/> Annual follow-up MNT
<input type="checkbox"/> Additional MNT services in the same calendar year, per RD recommendations _____ no. additional hrs. requested
<i>Please specify change in medical condition, treatment and/or diagnosis.</i>

Current Diabetes Medications
Specify type, dose and frequency
Oral:

Insulin:

Patient now uses: <input type="checkbox"/> Pen <input type="checkbox"/> Needle <input type="checkbox"/> Pump
Patient Behavior Goals/Plan of Care

Signature _____ NPI# _____ Date ___/___/___

Group/Practice name and phone # _____

