Sentara®

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Referral for Diabetes Self-Management Education/Training (DSME/T)

* Indicates required information for Medicare

Please complete this referral form and **FAX to Sentara Central Scheduling 1-844-648-0733**. To ensure that we have received the referral, a follow up phone call to 540-689-6000 is recommended.

Patient Name___ _____Date of Birth_____

Phone# (H) _____ (W) _____ (C)_____

Address_____

Health Insurance _____ Policy/ID# _____

*Diagnosis

_____ Type 2 controlled
_____ Type 2 uncontrolled, hypoglycemia
_____ Type 2 uncontrolled, hyperglycemia
_____ Pre-Diabetes

____Type 1 controlled
____ Type 1 uncontrolled, hypoglycemia
____ Type 1 uncontrolled, hyperglycemia
____ Other (describe) _____

____ Gestational Diabetes (GDM)
____ Diabetes with pregnancy
CIRCLE ONE
1st, 2nd,or 3rd Trimester

***Does this patient have conditions/barriers that make it difficult to participate in group education?**
Check and describe all that apply.

☐ Impaired vision ☐ Impaired hearing ☐ Impaired Cognition ☐ Physical Impairment ☐ Language Barrier _____
Please describe specific conditions

*Education /Training Ordered

Diabetes Self-Management Education/Training (DSME/T) and Medical Nutrition Therapy (MNT) are individual and complementary services to improve diabetes care. Both services can be ordered in the same year. Research indicates MNT combined with DSME/T improve outcomes.

(Medicare allows an initial 10 hours of group DSMT in a 12-month period, plus 2 hours of follow-up DSMT yearly)
***Check type of services and number of hours requested:**

☐ **Initial Group DSME/T for 10 hours/year (or indicate number of hours if less than 10 hours is needed ____)**
☐ **Follow Up DSME/T for 2 hours/year (or indicate number of hours if less than 10 hours is needed ____)**

***Check specific diabetes teaching needed:**

☐ **All content areas or as listed below**
- ☐ Disease process
- ☐ Healthy Eating
- ☐ Being Active
- ☐ Monitoring
- ☐ Taking Medications
- ☐ Healthy Coping
- ☐ Problem Solving
- ☐ Reducing Risks

☐ **Insulin teaching (or other injectable diabetes medication). Please list type and amount:**
_____

☐ **Medical Nutrition Therapy (by Registered Dietitian)**
Diet order: _____

Medicare coverage: 3 hours initial MNT in the first calendar year, plus 2 hours follow up MNT annually. Additional MNT hours available for change in condition, treatment and/or diagnosis.

☐ **Pre-Diabetes (Diabetes Prevention Program)**

*Documentation

Please send recent blood glucose and A1C values for insurance eligibility and outcomes monitoring.
Medications: _____

☐ See progress notes

(by signing this form, the provider verifies that this service is medically necessary)

*Referring provider's signature _____Date_____Time _____
Referring provider's name (printed) _____Provider NPI_____
Address _____ Phone _____