BAYLOR SCOTT & WHITE HEALTH
DIABETES EDUCATION PHYSICIAN ORDER

FAX completed form, COPY of insurance card, and labs (hemoglobin A1C, lipids, oral glucose tolerance test) to location of your choice:

Austin Round Rock Region
(includes Cedar Park, Georgetown, Pflugerville, Round Rock, and Taylor)

512-509-0200 phone
512-509-3490 fax

PATIENT INFORMATION
Patient Name: __________________________ Date of Birth: __________

☐ English-speaking ☐ Non-English Speaking language: (specify) __________________________

Address: _____________________________________________________________

Phone: (Primary) __________ (Secondary) __________

DIAGNOSIS
☐ Type 2, uncontrolled ☐ Type 1, uncontrolled ☐ Other: __________________________

☐ Type 2, controlled ☐ Type 1, controlled Diabetes due to: __________________________

☐ Pre-diabetes ☐ Gestational diabetes Complications: __________________________

**If patient is pregnant please check Pregnancy box in Medical Necessity below**

MEDICAL NECESSITY
☐ New Onset ☐ Pregnancy ☐ Change in Treatment ☐ Poor Glycemic Control

DIABETES SELF-MANAGEMENT TRAINING (DSMT) and MEDICAL NUTRITION THERAPY (MNT) SERVICES

<table>
<thead>
<tr>
<th>Education Service (select all that apply)</th>
<th>Hours (to request a different # of hrs please indicate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>X Initial DSMT</td>
<td>Type 2 (8-10 hrs)/Type 1 (6-8 hrs)/Pregnancy (4-10 hrs)</td>
</tr>
<tr>
<td>☐ Follow-up DSMT</td>
<td>2 hours</td>
</tr>
<tr>
<td>☐ Injectable Medication Teaching</td>
<td>2-4 hours</td>
</tr>
<tr>
<td>Name of Medication: ______</td>
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<tr>
<td>Dose: __________________________</td>
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<tr>
<td>Dosing Schedule: __________________________</td>
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</tbody>
</table>

☐ Teach or instruct on insulin titration per instructions below:

☐ Insulin Titration Instructions have been faxed with this order

☐ Request that insulin titration instruction template be faxed to our office

| X Initial MNT | 3 hours |
| Follow-up MNT | 2 hours |

DSMT Content: All ten content areas, as appropriate, will be covered unless otherwise specified.

- Monitoring diabetes
- Diabetes as disease process
- Nutritional management
- Physical activity
- Prevent, detect and treat acute complications
- Medications
- Goal setting, problem solving
- Psychological adjustment
- Prevent, detect and treat chronic complications
- Preconception/pregnancy

Medicare covers: DSMT 10 hours in a 12 month period, then 2 hours follow-up DSMT annually. Medicare MNT coverage includes 3 hours initial MNT in first calendar year, then two hours follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment, and/or diagnosis.

Patient CANNOT effectively participate in group instruction because of the following special needs and needs 1:1 appointment:

☐ Vision/Hearing ☐ Language Limitations ☐ Cognitive Impairment ☐ Other: __________________________

Physician Name (printed): __________________________ Phone #: __________________________ Fax #: __________________________

Physician Signature: __________________________ Referral Date: __________ Time: __________

If referring physician is not the patient’s primary care physician please provide name: __________________________

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BSWH-49245 (Rev. 01/16)
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