BAYLOR HEALTH CARE SYSTEM
DIABETES EDUCATION PHYSICIAN ORDER FORM

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

☐ English-speaking ☐ Non-English Speaking (language): _____

Address: _____

Phone: (Primary) _____ (Secondary) _____

DIAGNOSIS

☐ Type 2, newly diagnosed ☐ Type 1, newly diagnosed ☐ Gestational diabetes ☐ Pre-diabetes
☐ Type 2, uncontrolled ☐ Type 1, uncontrolled ☐ Pregestational diabetes ☐ Other: _____
☐ Type 2, controlled ☐ Type 1, controlled

MEDICAL NECESSITY

☐ New Onset Diabetes Mellitus ☐ Pregnancy ☐ Change in Treatment Plan ☐ Inadequate Glycemic Control

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

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

Check education program and number of hours requested:

☐ **Initial DSMT - Comprehensive Program or** ☐ **Follow-up DSMT - 2 hours**
*approximate hours for education programs listed below or physician can specify ____ hours of DSMT
Type 2 {8-10 hours}, Type 1 {6-8 hours}, Gestational {4-10 hours}, Pre-gestational {4-10 hours}

☐ **Teaching (insulin or other injectable)**
Name of Medication: _____
Dose: _____
Dosing Schedule: _____

☐ **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

☐ **Initial MNT - 3 hours or** ☐ **Follow-Up MNT – 2 hours (Patients with pre-diabetes receive MNT)**

☐ **Additional MNT services in the same calendar year,** per dietitian recommendations ____ # additional hours requested

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

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

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

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

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

☐ Baylor **Ft. Worth (All Saints)**
817-922-1794 (phone)
817-922-1951 (fax)

☐ Baylor **Garland**
972-487-5483 (phone)
972-485-3016 (fax)

☐ Diabetes Health and Wellness Institute (Dallas)
214-915-3200 (phone)
214-421-6561 (fax)

☐ Baylor **Plano**
469-814-6896 (phone)
469-814-6761 (fax)

☐ Baylor **McKinney**
469-764-1815 (phone)
214-818-9773 (fax)

☐ Baylor **Dallas**
(Ruth Collins & Ruth Collins at Mesquite)
214-820-8988 (phone)
214-820-8985 (fax)

☐ Baylor **Waxahachie**
972-923-8047 (phone)
972-937-2063 (fax)

Physician Name (printed): _____ **Phone #:** _____ **Fax #:** _____

Physician Signature: _____ **Referral Date:** _____ **Time:** _____
(signature stamps are not acceptable)

If referring physician is not the patient's primary care physician please provide name: _____

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BHCS-49245 (07/14)

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