Diabetes and Endocrine Center

A CIRCLE HEALTH MEMBER

Complete connected care℠

Diabetes Self-Management Education/Training Services Referral Form

Please complete **ALL** sections for appointment to be scheduled

PHONE #: (978) 323-0360 FAX TO: (978) 323-0362

_____ _____

Last Name First Name

Date of Birth:_____ Gender: ☐ M ☐ F

Address:_____City:_____State:_____Zip Code:_____

Best Contact #: _____ Interpreter Needed: ☐ No ☐ Yes – Language:_____

PCP:_____ Primary Insurance:_____

Diabetes Self-Management Education/Training (DSME/T)
Check type of training services or number of hours being requested

☐**Initial DSME/T:**

10 hours (1 individual + 9 group) OR _____No. hrs. requested
Once in a lifetime benefit and must be used within 12 consecutive months following start of DSMT

☐**Follow-up DSME/T:**

2 hours (either group or individual) OR _____No. hrs. requested every calendar year after Initial benefit is used

If ordering Medical Nutrition Therapy (MNT) and/or Evaluation/Management with Provider please see separate referral form
□Please check off box if sending separate MNT and/or Eval with Provider referral Appointment will not be made without additional form

Patients requiring individual (1 on 1) DSME/T hours versus group
Check all special needs that apply:

☐ Visual ☐ Language ☐ Insulin titration/Initiation

☐ Cognitive ☐ Change in medical condition ☐ Anxiety

☐ Hearing ☐ Additional time needed ____hrs.

☐ Physical

Diagnosis: **Pregnancy:** ☐**Y** ☐**N**

Last A1C:_____ Date:_____

☐Type 1 uncontrolled ☐Type 2 uncontrolled

☐Type 1 Controlled ☐Type 2 Controlled

☐Type 1 w/Pregnancy ☐Type 2 w/Pregnancy

☐Gestational ☐New Onset Diabetes ☐Pre-Diabetes

☐Impaired Glucose Tolerance ☐Impaired Fasting Glucose

Complications/Comorbidities (Check all that apply)

☐Hypertension ☐Kidney disease ☐Dyslipidemia

☐Non-healing wound ☐Neuropathy/gastroparesis

☐Mental/affective disorder ☐Retinopathy

☐Stroke ☐CHD/CAD ☐Obesity

☐Other _____

Clear Form

DSME/T Content - All content areas will be covered as needed per individualized education plan, unless otherwise specified
Monitoring Diabetes, Diabetes as disease process, Medications, Psychological adjustment, Physical Activity, Nutritional management Prevent/detect/treat complications, Goal setting/Problem solving, Preconception/pregnancy/GDM

By signing below, I certify that the above patient is under my care and that Diabetes Self-Management Education is a necessary part of the patient's medical treatment for the medical diagnosis(es) listed.

Referring Provider Signature:_____ **NPI:**_____ **Date:**_____

Referring Provider Printed: _____

THIS BOX Diabetes and Endocrine Center - OFFICE USE ONLY

*Order approved by:*_____ *Order approved date:*_____