

Diabetes Self-Management Education/Training (DSME/T), Medical Nutrition Therapy (MNT), and Intensive Behavioral Therapy (IBT) for Obesity Order Form

Patient Information

Patient's Last Name	First Name	Middle	
Date of Birth ____/____/____	Gender: ☐ Male	☐ Female	
Address	City	State	Zip Code
Home Phone	Other Phone		

Diagnoses/Complications/Comorbidities

Check all diagnoses that apply to this referral

- | | | | | |
|--|--------------------------------------|---|--|---------------------------------------|
| ☐ Type 1 | ☐ Type 2 | ☐ Kidney Disease | ☐ Hypertension | ☐ Dyslipidemia |
| ☐ CHD | ☐ Obesity | ☐ Neuropathy | ☐ Non-healing wound | ☐ PVD |
| ☐ Mental/affective disorder | ☐ Retinopathy | ☐ Pregnancy | ☐ Stroke | |
| ☐ Other: _____ | | | | |
| ☐ List ICD-10 dx codes: _____ | | | | |

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

Check type of training services requested

- ☐ Initial individual and/or group DSME/T (up to 10 hours)
☐ Follow-up DSME/T (up to 2 hours)

Medical Nutrition Therapy (MNT)

Check the type of MNT requested

- ☐ Initial MNT (up to 3 hours)
☐ Annual follow-up MNT (up to 2 hours)

Patients with special needs requiring individual (1 on 1) DSME/T

Check all special needs that apply:

- ☐ Vision ☐ Hearing ☐ Physical ☐ Cognitive Impairment
☐ Language Limitations ☐ Other: _____

Intensive Behavioral Therapy for Obesity (IBT)

BMI = ____kg/m² (Medicare: ≥ 30 kg/m² required)

DSME/T Content

Our program includes individual sessions and classes that cover the following:

- | | | |
|---|-------------------------------|---|
| Monitoring diabetes | Diabetes as a disease process | Psychosocial adjustment |
| Physical activity | Nutritional management | Goal setting, problem solving Medications |
| Prevent, detect and treat acute complications | | |

I certify that I am managing the patient's condition and that the education requested is needed to provide the patient with the necessary skills and knowledge to assist with therapy compliance and/or enable the patient to successfully manage his/her condition.

Provider Name (please print) _____

Signature and NPI# _____ Date ____/____/____

Provider Phone: _____ Provider Fax: _____

Fax completed form to: Diabetes & Nutrition Education at 507-457-7737. Call us for any questions at 507-457-4161.