KETTERING Health Network | Joslin Diabetes Center

Please FAX this order to: **(937) 401-6294**
Phone: **(937) 401-7588**

Date: _____

Patient's Name: _____ Phone: _____ DOB: _____

Primary Language: _____ Interpreter Needed Yes / No

DIAGNOSIS CODE: (ICD-10 diagnosis code is *mandatory* – please write in this space)

The following data must be received for an appointment to be scheduled (if info is not available in KHN Epic)

▼ Demographics ▼ Copy of Insurance Card ▼ Medication List ▼ Current Problem List ▼ Labs ▼ Last Appt. Notes

Referral to Endocrinology:

First appointment is scheduled with a diabetes educator for a 1 hr. Diabetes Self-Management Training (DSMT) assessment to provide for a comprehensive plan of care. This plan may include up to 10 hrs. of DSMT that covers the 10 ADA content areas, as appropriate. (4-6 visits). Unless otherwise noted.

CHECK ONE:

- ☐ Evaluation: Treatment: **three visits** with endocrinology, DSMT
- ☐ Evaluation: Treatment, and **long term care**, DSMT
- ☐ Evaluation: Treatment: #_____ visits, no DSMT
- ☐ Gestational: Includes group MNT education (patients to be scheduled within 48 business hours)

Referral to Diabetes Self-Management Training:

❑ **Plan of Care Development - Diabetes Assessment INDIVIDUAL,** 1 hour with Diabetes Educator
An individual plan of care will be developed based on assessment results, and returned to referring provider for approval and signature

❑ **GROUP Diabetes Self-Management Training**
10 hours with RN/RD
American Diabetes Assoc. ten content areas and glucose meter teaching PRN. (4-6 visits)

❑ **INDIVIDUAL Diabetes Self-Management Training**
10 hours with RN/RD unless otherwise noted____ hrs
American Diabetes Assoc. ten content areas and glucose meter teaching PRN. (2-6 visits)

*CMS coverage only allows for individual DSMT if barriers to learning exist. Check all that apply:

- ☐ Hearing
- ☐ Vision/Reading
- ☐ Cognitive Deficits
- ☐ Language
- ☐ Physical Limitations
- ☐ Other _____

❑ **Pre-diabetes GROUP class.**
3 hours with RD. (1 visits)

❑ **Injectable Medication Start INDIVIDUAL**
1 hour with RN. (1 visit) **Please specify:**
Medication: _____Dose:_____
C/I _____ CF: _____ Target: _____
Pen _____ Syringe _____

❑ **Advanced Carbohydrate Counting INDIVIDUAL**
3 hours with RD and 1 hour with RN (2-5 visits)

❑ **Gestational Group**
3 hours with RN/RD (2 visits)
Taught at Sycamore site

❑ **Insulin Pump Introduction GROUP and Insulin Pump Assessment INDIVIDUAL**
4 hours with RN and RD. (2-4 visits)

❑ **Medical Nutrition Therapy (MNT) INDIVIDUAL**
Up to 3 hours with RD **PHYSICIAN SIGNATURE REQ'D**

❑ **1-3 hour RN (1-3 visits)** _____

❑ **1–3 hour RD (1-3 visits)** _____

❑ **Other: 1 hr (1 visit)** _____

I certify I am managing this patient's diabetes, and that DSMT and/or MNT (including non-diabetes diagnosis) services are needed under a comprehensive plan of care to assist in therapy compliance and the obtaining of skills/knowledge to help manage this patient's diabetes. I understand that patient reports will be sent at the end of a class series and after subsequent follow-ups. If additional diabetes education needs are identified I will be notified so I can authorize a new plan of care.

_____ _____
Physicians Signature (required) Physicians Name (printed)

_____ _____
Office phone Number Office Fax

(Rev 12/07/15)