

**Medical Nutrition Therapy
Diabetes Self-Management
Training/Education**



**Caldwell: 13307 Miami Lane
Phone: 208.455.5423
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Clinics located in Caldwell, Emmett, Weiser

Patient's Last Name	First Name	Middle	Gender: <input type="checkbox"/> male <input type="checkbox"/> female	Medicare HICN # DOB:
Address				
Home Phone #	Work Phone #	Other Contact Phone #'s		

Diabetes self-management training (DSMT) and medical nutrition therapy (MNT) are individual and complementary services to improve diabetes care. Both services can be ordered in the same year. Research indicates MNT combined with DSMT improves outcomes.

REASON FOR SERVICE

<p>Diabetes Self-Management Training: <i>(Check type of education services being ordered)</i></p> <p><input type="checkbox"/> Initial training <input type="checkbox"/> Follow-up training</p> <p>Patient has special need(s) to receive individual instruction (check all special needs that apply)</p> <p><input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Language Limitations <input type="checkbox"/> Physical <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> No group training scheduled within 2 months <input type="checkbox"/> Other: _____</p>	<p>Medical Nutrition Therapy (MNT): <i>(Check services being ordered)</i></p> <p>Provided by a registered dietitian</p> <p><input type="checkbox"/> Initial MNT <input type="checkbox"/> Annual follow-up MNT <input type="checkbox"/> Additional MNT services in the same calendar year. <i>Please specify change in medical condition, treatment or diagnosis:</i></p> <p>_____</p> <p>_____</p> <p>_____</p> <p><i>Also list additional hours of MNT requested:</i></p> <p>_____</p>
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Diagnosis: (Please provide diagnosis code)

<input type="checkbox"/> Type 1	DX code: _____
<input type="checkbox"/> Type 2	DX code: _____
<input type="checkbox"/> GDM	DX code: _____
<input type="checkbox"/> Obesity	DX code: _____
<input type="checkbox"/> Pre-Diabetes	DX code: _____
<input type="checkbox"/> Other	DX code: _____

Complications/Comorbidities: (Check all that apply)

<input type="checkbox"/> Hypertension	<input type="checkbox"/> CHD
<input type="checkbox"/> Dyslipidemia	<input type="checkbox"/> Non Healing wound
<input type="checkbox"/> Stroke	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> PVD	<input type="checkbox"/> Mental/Affective Disorder
<input type="checkbox"/> Nephropathy	<input type="checkbox"/> Obesity
<input type="checkbox"/> Renal Disease	<input type="checkbox"/> Other:
<input type="checkbox"/> Retinopathy	<input type="checkbox"/> Other:

Please fax SWDH any relevant clinical information and recent labs including A1C and lipids:

Provider Printed Name: _____

Provider Signature and NPI#: _____ Date of Order _____

Group/Practice Name, Address, and Phone #, Fax # : _____