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

**Diabetes Self-Management Training:**  (Check type of education services being ordered)
- Initial training
- Follow-up training

**Patient has special need(s) to receive individual instruction (check all special needs that apply)**
- Vision
- Hearing
- Language Limitations
- Physical
- Cognitive Impairment
- No group training scheduled within 2 months
- Other: ______________________

**Medical Nutrition Therapy (MNT):**  (Check services being ordered)
- Provided by a registered dietitian
- Initial MNT
- Annual follow-up MNT
- Additional MNT services in the same calendar year.

*Please specify change in medical condition, treatment or diagnosis:

- ______________________
- ______________________

*Also list additional hours of MNT requested: ______________________

### Diagnosis: (Please provide diagnosis code)

<table>
<thead>
<tr>
<th>Type</th>
<th>DX code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
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<tr>
<td>Type 2</td>
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<tr>
<td>GDM</td>
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<tr>
<td>Obesity</td>
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<tr>
<td>Pre-Diabetes</td>
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<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

### Complications/Comorbidities: (Check all that apply)

- Hypertension
- Dyslipidemia
- Stroke
- PVD
- Nephropathy
- Renal Disease
- Retinopathy
- CHD
- Non Healing wound
- Pregnancy
- Mental/Affective Disorder
- Obesity
- Other:
- 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 #: ______________________

SWDH Client #: ______________________  Rev 10/2016