Harrison County Hospital
Referral for Diabetes Self-Management Education/Training (DSME/T)
***Indicates required information for Medicare.**
Fax completed and signed form to HCH Cardiology Fax: (812) 738-7823

Diabetes Self-Management Training - First Tuesday of every month
At Harrison County Hospital from 9 am – 2 pm - For more Information call: (812) 738-7887

Patient's name:_____**DOB:**_____**SSN:**_____

Home phone: _____**Work phone:** _____**Cell phone:**_____

Address:_____

Insurance company:_____ **Policy ID #:**_____

Precert required: yes or no /referral #:_____

Appointment date:_____**Arrival time:** **8:30 am** **Appointment time:** **9:00 am**

*DIAGNOSIS

☐ Type 2 controlled (E11.9)
☐ Type 2 uncontrolled, hypoglycemia (E11.649)
☐ Type 2 uncontrolled, hyperglycemia (E11.65)
☐ Type 1 controlled (E10.9)
☐ Type 1 uncontrolled, hypoglycemia (E10.649)
☐ Type 1 uncontrolled, hyperglycemia (E10.65)
☐ Other (describe)_____

***Does this patient have conditions/barriers that make it difficult to participate in group education? Check and describe all that apply.**_____
☐Impaired vision ☐Impaired hearing ☐Impaired cognition ☐Physical impairment ☐Language barrier
Please describe specific conditions_____

*Education/Training Ordered (G0109)

Diabetes Self-Management Education/Training (DSME/T) 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 DSME/T improve outcomes. (Medicare allows an initial 10 hours of group DSMT in a 12 month period, plus 2 hours of follow-up DSMT yearly)

***Check type of services and number of hours requested.**
☐ Initial Group DSME/T for 10 hours/year (or indicate number of hours if less than 10 hours is needed_____)
☐ Follow-up DSME/T for 2 hours/year (or indicate number of hours if less than 2 hours is needed_____)

***Check specific diabetes teaching needed:**
☐ **All content areas or as listed below**
☐ Disease process ☐ Healthy eating ☐ Being active ☐ Monitoring
☐ Taking Medications ☐ Healthy Coping ☐ Reducing Risks ☐ Problem Solving
☐ **Insulin teaching (or other injectable diabetes medication). Please list type and amount:**_____

*Documentation

Please send recent blood glucose and A1c values for insurance eligibility and outcomes monitoring.
Medications:_____
_____

☐ Hemoglobin A1C lab blood draw 90 days after attending class

*Physician's signature (required):_____ Date: _____

Physician name (print):_____Office phone: _____

Practice name: _____Office fax: _____