

**BAYLOR SCOTT & WHITE HEALTH  
DIABETES EDUCATION PHYSICIAN ORDER**

**FAX completed form, COPY of insurance card, and labs (hemoglobin A1C, lipids, oral glucose tolerance test) to location of your choice:**

<input type="checkbox"/> <b>Ft. Worth-All Saints</b> 817-922-1794 phone 817-927-6285 fax	<input type="checkbox"/> <b>Dallas</b> 214-820-8988 phone 214-820-8985 fax	<input type="checkbox"/> <b>Plano</b> 469-814-6896 phone 469-814-6761 fax	
<input type="checkbox"/> <b>Carrollton (MNT only)</b> 972-394-2414 phone 972-394-2474 fax	<input type="checkbox"/> <b>Diabetes Health Wellness Institute</b> 214-915-3200 phone 214-421-6561 fax	<input type="checkbox"/> <b>McKinney</b> 469-764-1815 phone 214-818-9773 fax	

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 English-speaking     Non-English Speaking language): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: (Primary) \_\_\_\_\_ (Secondary) \_\_\_\_\_

**DIAGNOSIS**

Type 2, uncontrolled     Type 1, uncontrolled     Other: \_\_\_\_\_  
 Type 2, controlled     Type 1, controlled    Diabetes due to: \_\_\_\_\_  
 Pre-diabetes     Gestational diabetes

**\*\*If patient is pregnant please check Pregnancy box in Medical Necessity below\*\***

**MEDICAL NECESSITY**     New Onset     Pregnancy     Change in Treatment     Poor Glycemic Control

**DIABETES SELF-MANAGEMENT TRAINING (DSMT) and MEDICAL NUTRITION THERAPY (MNT) SERVICES**

<b>Education Service (select all that apply)</b>	<b>Hours (to request a different # of hrs please indicate)</b>
<input type="checkbox"/> <b>Initial DSMT</b>	Type 2 (8-10 hrs)/Type 1 (6-8 hrs)/Pregnancy (4-10 hrs)
<input type="checkbox"/> <b>Follow-up DSMT</b>	2 hours
<input type="checkbox"/> <b>Injectable Medication Teaching</b> Name of Medication: _____ Dose: _____ Dosing Schedule: _____	2-4 hours
<input type="checkbox"/> <b>Teach or instruct on insulin titration per instructions below:</b> <input type="checkbox"/> Insulin Titration Instructions have been faxed with this order <input type="checkbox"/> Request that insulin titration instruction template be faxed to our office	
<input type="checkbox"/> <b>Initial MNT</b>	3 hours
<input type="checkbox"/> <b>Follow-up MNT</b>	2 hours

**DSMT Content: All ten content areas, as appropriate, will be covered unless otherwise specified.**

- Monitoring diabetes                      • Diabetes as disease process                      • Medications                      • Psychological adjustment
- Nutritional management                      • Physical activity                      • Goal setting, problem solving                      • Preconception/pregnancy
- Prevent, detect and treat acute complications                      • Prevent, detect and treat chronic complications

Medicare covers: DSMT 10 hours in a 12 month period, then 2 hours follow-up DSMT annually. Medicare MNT coverage includes 3 hours initial MNT in first calendar year, then two hours follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment, and/or diagnosis.

**Patient CANNOT effectively participate in group instruction because of the following special needs and needs 1:1 appointment:**

Vision/Hearing     Language Limitations     Cognitive Impairment     Other: \_\_\_\_\_

**Physician Name (printed):** \_\_\_\_\_ **Phone #:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Referral Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_  
*(signature stamps are not acceptable)*

**If referring physician is not the patient's primary care physician please provide name:** \_\_\_\_\_

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