Diabetes Self-Management Education/Training & Support Referral Form

Diabetes Self-Management Education/Training & Support (DSMET/DSMES) services offer a series of individual and group sessions with a Certified Diabetes Care & Education Specialist (CDCES) who will empower the patient to find practical solution that fit their personal needs to self-manage their diabetes.

Patient Information:

Patient's Legal Name (Last, First, Middle)____

Preferred Name ______________________ Date of Birth ____/____/_______Phone __________________________

Address _______________________________________ City ____________________ State _____ Zip__________

Diabetes Diagnosis:

Please send recent labs for patient eligibility & outcome monitoring

☐ Type 1 ☐ Type 2

☐ Gestational ICD-10 Code: _____________

Check type of training service and number of hours requested:

☐ Initial Comprehensive DSME/T (10 hours)

☐ Follow-Up DSME/T (2 hours)

Indicate any barriers to group learning or additional insulin training requiring hours of 1:1 training:

☐ Impaired mobility ☐ Impaired dexterity

☐ Impaired vision ☐ Impaired hearing

☐ Impaired cognition ☐ Language barrier

☐ 1:1 Insulin Training

☐ Other: ______________________________

Complications/Comorbidities:

☐ Hypertension ☐ Dyslipidemia ☐ Stroke

☐ Neuropathy ☐ PVD ☐ Obesity

☐ Kidney Disease ☐ Retinopathy ☐ CHD

☐ Non-healing wound ☐ Pregnancy

☐ Mental/affective disorder ☐ Other________________

Definition of Diabetes (Medicare)
Medicare coverage of DSMT requires the physician to provide documentation of a diagnosis based on one of the following: • A fasting blood sugar greater than or equal to 126 mg/dL on two different occasions; • A 2-hour post-glucose challenge greater than or equal to 200 mg/dL on 2 different occasions; or • A random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes. Other payors may have other coverage requirements.

I hereby certify that I am managing this beneficiary's diabetes condition and that the above prescribed training is a necessary part of management:

Referring Provider (print name)____ **NPI #** ___________________

Signature ____ **Date** _____/_____/_________

Group/Practice Name ____ Phone ______________________

Address _______________________________________ City ___________________ State ______ Zip__________

If you have any questions, please contact program staff by calling (954) 319-4254

Please fax completed Referral Form to: (954) 771-7952