Tri-State
MEMORIAL HOSPITAL &
MEDICAL CAMPUS

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Outpatient Diabetes Self-Management Education
Provider's Order Form

Patient's Name:_____ **Date of Birth:**_____ **Phone:** _____

Address: _____

Referring provider: _____ **Referral Date**: _____

Primary insurance:

To meet CMS eligibility criteria one of the following must be met **(please check all that apply): ICD 9 codes**

- ❑ Fasting blood sugar greater than or equal to 126mg/dL on two different occasions **250.**_____
- ❑ 2 hour post glucose challenge greater than or equal to 200mg/dL _____._____
- ❑ Random glucose test over 200 mg/dL for a person with symptoms of diabetes _____._____
- ❑ **Type 1 Type 2 Gestational**

❑ **Initial Training:** Patient to receive a 1:1 initial assessment and education in the AADE- 7 Diabetes Self-Care goals which include:

1. Healthy eating
2. Being active
3. Taking medication
4. Monitoring
5. Problem solving
6. Healthy coping
7. Reducing risks

Medicare allows 10 hours of initial training, 9 of the 10 hours must be provided in a group setting unless special conditions exist. Please document any special needs of the patient: ☐Vision ☐Hearing ☐Language ☐Physical ☐Cognitive Impairment
Other:_____
Other insurances vary in coverage.

❑ **Follow up training:** (either group or individual is allowed) 2 hours per year is the usual coverage
Please specify any special needs:

❑ ***i*PRO 2 Continuous Glucose Monitoring**

Medicare Criteria for coverage of CGM T1 or T2 Diabetes, Been instructed by a health care professional in the management of diabetes, Documented frequency of glucose testing (4x/Day) during the previous month, Been on a Program of Multiple Daily injections (2 per day min) with self adjustment **AND** met one of the following:

- o A1C (<4 or >9), Unexplained large fluctuations in daily glucose values before meals, Unexplained frequent hypoglycemic attacks
- o Episodes of Ketoacidosis or hospitalized out of control, Type 1 or Type 2 Diabetic woman who is newly pregnant or a woman who has developed a gestational diabetes that requires insulin therapy

Records needed from patient record: ☐**check if records are in Greenway EMR TSMH & MC**

If not please send the following:

- ❑ H&P
- ❑ Current list of medication
- ❑ Lipid
- ❑ CMP
- ❑ A1C
- ❑ Other pertinent lab results

Other needs identified by PCP: _____

_____

Ordering care provider's signature: _____ Date: _____