# Nutrition Services Order Form (DSMT and MNT Services)

## PLEASE FAX TO: 757.499.2017

**PATIENT INFORMATION** ***Indicates areas that must be completed for Medicare patients**

Patient's Last Name ______________________________ First Name ______________________________ Middle ________________

Date of Birth ____/____/____ Medicare/Insurance# ____________________/Carrier: ______________ Gender ____Male ____ Female

Address City State Zip Code

Home Phone Work Phone Other Contact Phone

Diabetes self-management training (DSMT) and medical nutrition therapy (MNT) are individual and complementary services to improve diabetes care. For Medicare beneficiaries, **both** services can be ordered in the same year. Research indicates MNT combined with DSMT improves outcomes.

## DIABETES SELF-MANAGEMENT TRAINING (DSMT)

**Medicare: 10 hours initial DSMT in 12-month period, plus 2 hours follow-up DSMT annually**

**Check type of training services and number of hours requested:*

- ☐ Initial group DSMT: ☐ 10 hours or ____ no. hrs. requested
- ☐ Follow-up DSMT: ☐ 2 hours or ____ no. hrs. requested
- ☐ Additional insulin training: ____ no. hrs. requested

*** Patients with special needs requiring individual DSMT**

*Check all special needs that apply:*

- ☐ Vision ☐ Hearing ☐ Physical ☐ Cognitive Impairment
- ☐ Language Limitations ☐ Other ____________________

*** DSMT Content**

- ☐ All ten content areas, as appropriate
- ☐ Monitoring diabetes
- ☐ Diabetes as disease process
- ☐ Psychological adjustment
- ☐ Physical activity
- ☐ Nutritional management
- ☐ Goal setting, problem solving
- ☐ Medications
- ☐ Prevent, detect and treat acute complications
- ☐ Preconception/pregnancy management or gestational diabetes management
- ☐ Prevent, detect and treat chronic complications

## * DIAGNOSIS

*Please send recent labs for patient eligibility & outcomes monitoring*

- ☐ Type 1 uncontrolled ☐ Type 1 controlled
- ☐ Type 2 uncontrolled ☐ Type 2 controlled
- ☐ Gestational diabetes ☐ Other ____________________

**Complications/Comorbidities**

*Check all that apply:*

- ☐ Hypertension ☐ Dyslipidemia ☐ Stroke
- ☐ Neuropathy ☐ Nephropathy ☐ PVD
- ☐ Renal disease ☐ Retinopathy ☐ CHD
- ☐ Non-healing wound ☐ Pregnancy ☐ Obesity
- ☐ Mental/affective disorder ☐ Other ____________________

## MEDICAL NUTRITION THERAPY (MNT)

**Medicare: 3 hours initial MNT in the first calendar year, plus two hours follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis.**

** Check the type of MNT and/or number of additional hours requested:*

- ☐ Initial MNT ☐ Annual follow-up MNT
- ☐ Additional MNT services in the same calendar year, per RD recommendations ____ # additional hrs. requested
- ☐ Dietitian to determine hours per recommended guidelines

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

## CURRENT DIABETES MEDICATIONS

**Specify type, dose and frequency**

Oral:

Insulin:

Patient now uses: ☐ Pen ☐ Needle ☐ Pump

## Office Use Only:

❑Pt called ____/_____ Appt. Date: __/___/__

Chart Note to MD sent: ❑Yes (Date: _____/Initials: _____)
❑No ______________________________

No Call/No Show: ______________________________

*Signature and UPIN #______________________________/UPIN: ______________ *Date____/____/____

Group/practice name, address and phone: ______________________________


Live It Healthy 4LIFE™ Diabetes, Nutrition & Wellness Center
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