Boone Hospital Center
Columbia, Missouri

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Diabetes Self-Management Program

1701 E. Broadway Suite 102, Columbia, MO
Phone: 573-815-3870 Fax: 573-815-3816

General Information - Face sheets can be attached

Name (Print)_____**SS#**_____ **Date of Birth**_____
Home Phone_____ **Work Phone** _____
Insurance _____
Authorization Number_____ **(Please send a copy of authorization if HMO plan)**
Primary Physician_____**Referring Physician**_____
Office Nurse Name: _____**Office Phone:** _____**Office Fax:** _____

NOTE IF MEDICARE, Education is medically necessary due to: (Mark all that apply)
(Please send copies of these labs for our files)

- □ A fasting blood sugar greater than or equal to 126mg/dL on two different occasions
- □ A 2 hour post glucose challenge greater than or equal to 200mg/dL on two different occasions
- □ A random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes

Referral for: _____
Please mark appropriate diagnosis:

- □ E11.9 Type 2 diabetes mellitus without complications
- □ E11.65 Type 2 diabetes mellitus with hyperglycemia
- □ E10.9 Type 1 diabetes mellitus without complications
- □ E10.65 Type 1 diabetes mellitus with hyperglycemia
- □ O24.319 Unspecified pre-existing diabetes mellitus in pregnancy, unspecified trimester
- □ O99.810 Abnormal glucose complicating pregnancy

Please mark service desired:

CLASSES

- □ Includes 10 hours DSMT & 3 hours MNT & 72 hour continuous glucose monitoring

INDIVIDUAL SERVICES

- □ Diabetes Self-Management Training (DSMT) Number of hours and topics to cover: _____
- □ Medical Nutrition Therapy (MNT) – 3 hrs
- □ Insulin therapy initiation
- □ Continuous Glucose Monitoring
- □ Insulin Pump Therapy
- □ Gestational Diabetes
- □ **Follow-up Training** had class series previously but greater than 1 year. Medicare covers 2 hours DSMT & MNT annually.

NOTE IF MEDICARE: **Indicate barriers to group education if individual DSMT is desired:**
Barriers to learning: □ **Vision** □ **Hearing** □ **Language** □ **Impaired mental status** □ **Other** (specify: _____)

I hereby certify that I am managing this beneficiary's Diabetes condition and that the above prescribed training is a necessary part of management. (Medicare patients)

Physician's/HCP Signature: _____ Date: _____ Time: _____

DSME can be ordered by an MD, DO or midlevel provider managing the patient's diabetes.
**MNT must be ordered by MD or DO.

Please send most recent labs and office note with referral.