HOUSTON Methodist LEADING MEDICINE

# Physician ORDER FORM
# Diabetes Self-Management Education & Medical Nutrition Therapy

* **Indicates Required Information for Medicare patients**

## PREFERRED LOCATION & DEMOGRAPHICS

☐ **Med Center** ☐ **Sugar Land** ☐ **West Houston** ☐ **Willowbrook (SCHEDULING PHONE: 713-441-5975 | FAX: 713-790-6366)**

☐ **San Jacinto (SCHEDULING PHONE: 281-420-8525 | FAX: 281-420-8780)**

| PATIENT'S NAME | DATE OF REFERRAL | DOB | SEX M F |
|---|---|---|---|
| PRIMARY PHONE | ALT PHONE | PATIENT ADDRESS | |
| PATIENT INSURANCE | | | |

## COMPLETE ALL PERTINENT DIAGNOSIS ICD 10 CODES

| | | | | | |
|---|---|---|---|---|---|
| Type 1 Diabetes | E10._____ | Obesity | E66._____ | Thyroid | ____.___ |
| Type 2 Diabetes | E11._____ | Metabolic Syndrome | E88._____ | GI | ____.___ |
| Other Diabetes | E13._____ | Hypertension | I10. _____ | Liver | ____.___ |
| Impaired/Abnormal Glucose | R73._____ | High Cholesterol | E78._____ | Cancer | ____.___ |
| Gestational Diabetes | O24._____ | Renal | N18._____ | Other | ____.___ |

## * DIABETES EDUCATION: Complete Entire Section Below if Referring for Diabetes Self-Management Education (DSME)

**1.** Check type of services needed and number of hours requested:
- ☐ Initial Comprehensive Diabetes Ed - up to 10 hrs and all 9 ADA core topics
- ☐ Follow-Up Education – up to 2 hrs
- ☐ Specific topics and hours if needs vary from above:_____

**2.** Indicate any special needs requiring Individual or Customized Education:
- ☐ Language ☐ Vision/Hearing/Physical ☐ Insulin Training ☐ Recent Organ Transplant
- ☐ Literacy ☐ Carb to Insulin Ratio Ed ☐ Pump Overview ☐ Other _____

**3.** ☐ By checking this box, I hereby certify that I am managing this patient's Diabetes condition and that the above prescribed training is a necessary part of management.

## * MEDICAL NUTRITION THERAPY: Complete Section if Referring for Medical Nutrition Therapy (MNT)

Check type of services requested:

☐ Initial MNT – up to 3hrs ☐ Follow-up MNT – up to 2 hrs ☐ Weight Loss Education/Programs

## LABS

Attach recent lab work and progress notes.

## REFERRING PHYSICIANS

Additional Instructions

| Physician's Name & Address | Physician NPI | **Contact for Questions:** |
|---|---|---|
| | | Contact Name: _____ |
| Physician's Signature | Date | Phone No. _____ |
| | | Fax No. _____ |