Methodist
MANSFIELD MEDICAL CENTER

Outpatient Diabetes Education Program
2700 E. Broad Street
Mansfield, TX 76063
Phone: 682-242-4456
Fax: 682-242-4110

Physician Order for Diabetes Education Form

****FAX TO (682) 242-4110 WITH COPY OF PATIENT INSURANCE AND LABS****

Patient Name: ____ DOB:____________________

Address:______________________________City:___________State: ______Zip Code:________

E-mail:____Home Phone: ___________________

Cell Phone: ____________________ Language:___________________________

Physician Name & NPI: _______________________________ Physician Phone: _______________

Diabetes Diagnosis

___Type 1___Type 2 __Gestational __Pre-Gestational Diagnosis Code: _______________

DSMES ORDERS:

If # of hours are not specified, DSMES team will default to number of hours allowed per benefit.

Initial DSMES ________hours Follow-up DSMES________hours

DSMES CONTENT AREAS/PLAN OF CARE:

Initial Comprehensive DSMT classes are conducted in one 1-hr individual visit and four 2-hr group sessions:
____All content as related to diabetes care plan and agreed upon by the Patient and DSMES team **OR** only specific content areas: _ Healthy Coping _ Monitoring _Taking Medication _ Healthy Eating _Reducing Risks _Being Active _Problem solving

____Insulin Initiation Training

____Gestational Diabetes or Pre-gestational training

____Other_______________________________

SPECIAL NEEDS(OPTIONAL) MEDICARE BENEFICIARIES

*Please check reason **if** more than 1 of 10 hours of Initial DSMT are being requested individually instead of in a group setting.*

__Impaired Vision __Impaired Hearing __Language barrier __Cognitive impairment
__Physical __Psychosocial __Transportation __Other:______

MEDICARE COVERAGE:.
DSMT: 10 hours initial DSMES in 12- month period from the date of first encounter, plus 2 hours follow-up per calendar year with signed referral from the treating qualified provider (MD/DO, APRN, NP or PA) each year. DSMES and DSMT are the same thing: DSMT is the name of the Medicare benefit.

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 participants)
Any changes to this beneficiary's above plan of care will require a new referral signed by the provider

Physician Signature: ____________________________Date: ______________

Physician Fax Number: ____________________________________