The Johns Hopkins Diabetes Center

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Diabetes Services Order Form (DSMT and MNT Services) *Indicates required information for Medicare order

PATIENT INFORMATION (stamp)

Medicare HICN # ____________________
(If applicable)

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.

Education Needs: To be completed by referring professional:

☐ Diabetes Self Management Training
☐ Medical Nutrition Therapy: ☐ CHO Awareness ☐ CHO Counting ☐ Weight loss ☐ Exercise
☐ Other (specify) ____________________

Signature UPIN OR NPI # ____________________ *Date __/__/__

FOR OFFICE USE

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

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 samé calendar year, per RD recommendations ___ no. additional hrs. requested

* DIAGNOSIS

Please send recent labs for patient eligibility & outcomes monitoring.
I certify that patient has 2 FBS over 125 mg/dL conclusive with diagnosis of:

☐ 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 ____________