

Fax to: (510) 419-0880

Family Bridges, Inc. Diabetes Education Center
Diabetes Services Order Form (DSMT & MNT)

Patient Name: _____	Date of Birth: _____
Patient Address: _____	
Phone Number: (home) _____	(work/other) _____
Patient Insurance: _____	
Authorization Required? Yes No	Authorization # _____

Requested Service:

- _____ Diabetes Self-Management Training (DSMT) **Class Series** (10 hours, Comprehensive)
- _____ Individual **Medical Nutrition Therapy** (MNT)
- _____ **Annual follow up:** 2 hours, as needed. (standard DSMT or MNT follow up)
- _____ **Insulin Injection Training:** RX and Dose: _____
 - Educator to evaluate dose and make insulin adjustments until stable
- _____ Reassessment and continued intervention

Group education is required by Medicare, with some exceptions. Certify any reasons below:

- Special needs for hearing, vision, language, or physical limitations
- Special needs for cognitive challenge
- On insulin or insulin start

DIAGNOSIS

- Type 1 uncontrolled
- Type 2 uncontrolled
- Type 1 controlled
- Type 2 controlled
- Gestational Diabetes
- Other _____

Complications/Comorbidities

- Hypertension
- Dyslipidemia
- Obesity
- Neuropathy
- Retinopathy
- CKD, stage _____
- Stroke
- PVD
- CHD
- Pregnancy
- Non-healing wound
- Mental/affective disorder
- Other _____

Diabetes Medications: None _____

Oral glucose-lowering agent(s) _____

Insulin regimen _____

Other relevant meds _____

Lab data: A1C _____ Microalbumin _____ Creatinine or GFR _____

Cholesterol _____ HDL _____ LDL _____ Triglycerides _____

Or Attach Lab Copy.

Signature of Attending Physician _____ Date: _____

UPIN# _____ NPI# _____

Practice name, address, and phone (use stamp):