SOUTHERN ILLINOIS HEALTHCARE

Orders – Outpatient Education Referral Form

(Nutrition and Diabetes Education: DSMT and MNT services)

Patient Last name	First	M	Gender ☐ Male ☐ Female DOB	Ethnicity/Race
Address	City	State	Zip	☐ Medicare ☐ Medicaid ☐ Insurance
Home Phone	Work Phone	Last 4 digits of Social Security #		

Diabetes self-management training (DSMT) and medical nutrition therapy (MNT) are individual and corresponding services to improve diabetes care. Both services can be ordered in the same year. Research indicates MNT combined with DSMT improves outcomes.

Referring patient for treatment at:

☐ Memorial Hospital of Carbondale ☐ Herrin Hospital ☐ St. Joseph Memorial Hospital

Diagnosis (inclusion of diagnoses on this list does NOT guarantee insurance coverage)

Diabetes: ☐ Type 1 controlled ☐ Type 1 uncontrolled ☐ Type 2 controlled ☐ Type 2 uncontrolled ☐ Gestational ☐ IFG

Other: ☐ Obesity ☐ Overweight ☐ CKD – IV ☐ Heart Disease ☐ Other

Complications/Comorbidities: (Check all that apply)

☐ Hypertension ☐ Dyslipidemia ☐ CHD
☐ Neuropathy ☐ PVD ☐ Pregnancy
☐ Renal Disease ☐ Retinopathy ☐ Obesity
☐ Non-healing wound ☐ Stroke
☐ Mental/Affective Disorder ☐ Nephropathy
☐ Other:

Medical Nutrition Therapy (MNT):

Provided by a registered dietitian (RD)

☐ Initial MNT up to 3 hours.

☐ Annual follow-up MNT up to 2 hours

☐ Additional MNT services in the same calendar year. Please specify change in medical condition, treatment or diagnosis:

_____

_____

Also list additional hours of MNT requested: _____

Patient's Goals: _____

Current labs/clinical data: **Date:** _____

(Please send recent labs for outcomes evaluation)

☐ A1C _____ ☐ B/P _____ ☐ LDL _____
☐ FBS _____ ☐ Other _____
Height _____ in. Weight _____kg.
OGTT Fasting _____ 1 hr. _____ 2 hr. _____ 3 hr. _____

Desired Clinical Outcomes:

(Evidence-based reference values:A1C< 7.0 B/P< 130/80 LDL< 100mg/dl)

☐ A1C _____ ☐ B/P _____ ☐ LDL _____
☐ FBS _____ ☐ Other _____

Diabetes Self Management Training (DSMT):

(Check type of education services ordered) - Provided by RN or RD

☐ Initial training up to 10 hours first year

Patient has special need(s) to receive individual instruction

☐ Vision ☐ Hearing
☐ Language Limitations Primary Language _____
☐ Physical ☐ Cognitive Impairment
☐ No group training scheduled within 2 months
☐ Other _____

☐ Follow-up training up to 3 hours the following year

☐ Group training up to 8 hours

Diabetes Medications: (type, dose, frequency, date started)

Oral: Injectable:

Accommodations Requested:

Additional Pertinent Information:

_____ _____ _____

Signature Ordering/Supervising Physician/NPI# Date Time

☐ Report requested

Group/Practice Name, Address, Phone Number (ChartMaxx users: Documentation available in ChartMaxx)

Fax this form to 618-351-6476