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| --- |
| **C:\Users\Owner\AppData\Local\Temp\Temp1_Driftless Diabetes management LOGO.zip\Final Logo\Stacked Logo - Black.png** |
|  |
| \*Patient’s Name \*DOB |
|  |
| \*Address  |
|  |
| \*Home Phone Work Phone Other Contact Phone |
|  |
| \*Patient’s Health Insurance ID# |
|  |
| **\*Diagnosis**  |
|  |
| Diagnosis ICD 10 Code |
|  |
| **\*Requested Services** Coverage for requested services varies by insurance. |
| [ ]  Diabetes management (Physician’s Assistant & CDCES)[ ]  Diabetes Self-Management Education/Training (RD/CDCES only)[ ]  Medical Nutrition Therapy (RD only)[ ]  Additional MNT services in the same calendar year, \_\_\_\_\_\_# of hours requested. Specify change in medical condition, treatment, and/or diagnosis: [x] Individual Education/Training Session(s)--***Check all that apply***[ ] Vision impairment [ ] Hearing impairment [ ] Physical limitations [ ] Language limitations [ ] Cognitive impairment [ ]  Individualized insulin training [x] Other: No group session available within 2 months. |
| **\*Plan of Care** |
| [x]  Diabetes Services Staff to assess patient’s knowledge and provide education as needed.  Content areas (per guidelines for an ADA recognized program): Describing the diabetes disease process and treatment options, incorporating nutritional management into lifestyle, incorporating physical activity into lifestyle, using medication(s) safely and for maximum therapeutic effectiveness, monitoring blood glucose and other parameters and interpreting and using the results for self-management decision making, preventing, detecting, and treating acute complications, preventing detecting, and treating chronic complications, developing personal strategies to address psychosocial issues and concerns, developing personal strategies to promote health and behavior change. |
| **\*Certification Statement** |
| [x]  I certify Diabetes Self-Management Education/Training and Medical Nutrition Therapy are needed under a comprehensive plan for this patient’s diabetes care. |
| Physician Signature Date / / Physician Name and NPI Office Contact name: Telephone Number:  |
| Please fax completed form to \*FAX NUMER\* or email to Jackie@driftlessdiabetes.com | Driftless Diabetes Management, LLC285 S Winsted St Spring Green WI 53588\*WEBSITE\* |