

Certification of Medical Necessity for Diabetes Self-Management Training

Diabetes Education
Duncan Regional Hospital

Phone: 580-251-8461
Fax: 580-251-8892

| | | | | |
|--------------|----|--|---------------|---------------|
| Patient Name | | | Date | |
| Address | | City/State | | Zip |
| Ht | Wt | Sex: <input type="checkbox"/> M <input type="checkbox"/> F | Daytime Phone | Date of Birth |

Reason for Ordering Training (Check all that apply)

- New Onset Diabetes (Diagnosed within last 12 months). Type 1 (250.01) Type 2 (250.00)
 Gestational (648.83)
- Inadequate glycemic control / Out of Control: Type 1 (250.03) Type 2 (250.02) indicated by:
 HgbA1c \geq 8.5% within last three months: HgbA1c _____ Date _____; **OR**
 Documented acute episode of severe hypoglycemia or acute hyperglycemia occurring in the past year during which the patient needed emergency room visits or hospitalization.
- Pre-Diabetes (please list symptoms): _____
- Change in condition/treatment regimen.
 Initiation/addition of Oral Medication (name) _____
 Initiation/addition of Insulin (name) _____
 Other _____
- High risk based on one or more of the following documented complications:
 Coronary artery disease Hypertension
 Nephropathy/kidney disease Neuropathy/nerve damage
 Peripheral vascular disease Retinopathy/visual impairment

Training Ordered

- Type 1 Self-Management Training (2-3 visits) **Frequency of testing:**
 Type 2 Self-Management Training (3 visits) daily 2 - 3 x day
 Gestational Diabetes Training (648.83) 3 x day 4 x day
 Other meds: _____
- Other Concerns: _____

- This patient **CANNOT** effectively participate in group instruction and therefore requires individual session due to:
 Language barrier
 Visual/hearing impaired
 Other _____

I certify the diabetes self-management training is needed under a comprehensive plan for this patient's diabetes:

- To ensure therapy compliance and/or
 To provide the necessary skills & knowledge to enable the patient to manage his/her condition.

Complete the following /or fax the results: B/P _____ FBS _____ HgbA1c _____
 OGTT _____ Chol _____ HDL _____ LDL _____ Trig _____

Signature: Must be hand signed - stamped signature not acceptable.

Physician's signature: _____ Date/Time: _____
 Physician's name (printed) _____

Please fax form to Diabetes Education @ 251-8892