American Diabetes Association. Education Recognition Program

CARROLL HOSPITAL
A LifeBridge Health Center
CARE BRAVELY

The Diabetes Program
291 Stoner Avenue
Westminster, MD 21157
410-871-7000

Order Form for the Diabetes Program at Carroll Hospital

Thank you for referring your patient to the Diabetes Program. This form may be used to refer patients with **diabetes** (A1C >6.5%) or **prediabetes** (A1C 5.7-6.4%).

Patient Information:

Name:		Birthdate:
Address:		City:
State	Zip	Best Phone Number:

Diagnosis: □ Type 1 □ Type 2 □ Prediabetes □ LADA □ Gestational

Diagnosis Code: _____Most Recent HbA1c result/date:_____%/_____

Services Requested: (Please check DSMT and MNT for initial referrals)

__ Initial Diabetes Self-Management Training (DSMT)- 10 hours and all 9 topics.
Medicare covers DSMT as a 1-hour individual session and 9 hours of group classes UNLESS a special need requiring individual sessions is checked: □ Vision □ Hearing □Cognitive □Language □ Mobility □Insulin Training □Other: _____
Specify topics and hours if less than 10 hours:_____

__ DSMT follow-up: 2 hours

__ Prediabetes Education

__ Medical Nutrition Therapy (MNT) initial: 3 hours

__MNT follow-up: 2 hours

__Additional number of MNT hours requested: _____ due to _____

Prescriber's signature and date required:

I hereby certify that I am managing this beneficiary's diabetes or other stated condition and that the above prescribed training is a necessary part of management:

Prescriber Name (printed)_____

Phone #: _____ Fax #: _____ NPI#:_____

Prescriber signature:_____Date:_____

FAX this completed form and copy of patient's insurance card to the Diabetes Program: 410-871-7370