MidMichigan Health
UNIVERSITY OF MICHIGAN HEALTH SYSTEM

Consult to Diabetes Center

MidMichigan Medical Center – Midland
Fax (989) 839-1388
Phone (989) 839-3123 or (800) 727-3123

For Diabetes Center Use

Patient Information

Name ____ Gender ❑ M ❑ F

DOB: ____________ Phone: (H) _____________ (Other)_______________

Insurance: ______________________ Lab work: A1c: _____ Date ______ Other: ________ Date ________

Diagnosis (required for reimbursement)

❑Type 2 ❑ Type 2, uncontrolled	❑ Type 1 ❑ Type 1, uncontrolled	❑ Gestational Diabetes ❑ Diabetes with Pregnancy	❑ Pre Diabetes ❑ Other _______________

Complications /Comorbidities

❑ Hypertension ❑ Peripheral vascular disease ❑ Stroke	❑ Neuropathy ❑ Retinopathy ❑ Renal Disease	❑ Dyslipidemia ❑ Obesity ❑ Morbid Obesity	❑ CAD ❑ Other:

Reason for Training

❑ New Onset of Diabetes ❑ Inadequate Glycemic Control ❑ Recurrent hypoglycemia or ❑ Recurrent hyperglycemia ❑ Training on GLP-1 administration	❑ Change in Treatment regimen: ❑ Other:

DSMT: Diabetes Self-Management Training with Nurse and Dietitian

Medicare allows 10 hours initial training in 12 month period, plus 2 hours follow up annually.

❑ **Initial *GROUP* DSMT** (10 hours or _______ hours requested)**;** requires initial 1:1 assessment
Class includes all 10 content areas as appropriate or specify content: ____

❑ **Initial *INDIVIDUAL* DSMT** (10 hours or _______ hours requested)

Medicare/Medicaid recipients must meet one of the following special needs for individual visits (specify):

❑ Vision ❑ Hearing	❑ Physical Limitations ❑ Language Limitation	❑ Cognitive Impairment ❑ Other (specify):

❑ F**ollow-up DSMT** 2 hours or ______ # hrs requested

❑ **Gestational Diabetes Management EDC** = ___________
❑ Use Staged Diabetes Management protocols for doses and insulin adjustment

MNT: Medical Nutrition Therapy with Dietitian

MNT is a yearly Medicare benefit; 3 hours initial benefit; 2 hours/year annual benefit with no copay

❑ Initial MNT 3 hours or _____ # hrs requested
❑ Annual follow-up MNT 2 hours or _____ # hrs requested
❑ Additional MNT in same calendar year (specify change in medical condition, treatment or diagnosis:
❑ PreDiabetes Class or Consult

Other Orders:

❑ ***Insulin Start or Adjustment** (check one of following)
❑ Patient to contact provider for all adjustments. Starting Dose: ____________________________
❑ Use Staged Diabetes Management protocols for doses and insulin adjustment
❑ **Instruction for orals when insulin is begun*:*** _____________________________________

❑ **Continuous Glucose Monitoring (CGM) –** includes diabetes self-management training for identified needs
CGM sensor worn for 5 to 7 days for data collection, download and report to physician.

❑ **Insulin Pump Evaluation, Initiation and Follow-up**

❑ **Foot Clinic** Appointment (reason: ____)

Diabetes Center will contact pt to schedule appt.

Physician/Midlevel Provider Signature ___________________________________ **Date:** ____________________

Provider Name (printed) __________________________________ (MD or DO referral required for MNT and for Medicaid)

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