NEWTON-WELLESLEY HOSPITAL

Doctor's Order

Certificate of Medical Necessity for Diabetes Self-Management Training

Patient Name:_____ MR #:_____Date:_____
Telephone No._____(Work):_____Date of Birth:_____

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1. DIAGNOSIS: ☐ Type 2 Diabetes ☐ Type 1 Diabetes ☐ Gestational Diabetes ☐ PreDiabetes
☐ Hypoglycemia ☐ Pregnancy

2. REASON FOR REFERRAL (check all that apply)**:**
☐ New Onset of Diabetes ☐ Uncontrolled Diabetes ☐ Change in Medication Treatment of Diabetes
☐ High Risk for Complications (Documented Episodes of Severe Hypoglycemia/Hyperglycemia Requiring an Emergency Room Visit or Hospitalization in the Past Year)
☐ Complications of Diabetes: ☐ HTN ☐ Dyslipidemia ☐ Foot Ulcers/Deformities ☐ Neuropathy
☐ Renal Disease ☐ Retinopathy
☐ Pre-Insulin Pump Evaluation

3. RECENT LAB VALUES NEEDED: ➢ 2 FBS of ≥126 or a random BS of ≥200: ¬ _____ - _____
➢ HbA1c _____ ➢ urmicroalb/cr _____ ➢ TChol _____ ➢ TG _____ ➢ LDL _____ ➢ HDL _____

4. EDUCATION TRAINING, TREATMENT AND FREQUENCY:
☐ Education or Improved Understanding of Disease Process, Risk Reduction and Complication Prevention
Specify Topic: _____# of Hrs. Requested: _____ (<10hrs)
☐ Consultation/Comprehensive Program (10 hours; 1 hour individual initial assessment; 9 hours of group class unless otherwise indicated *). All patients receive an initial individual assessment by a RN and RD. The patient progresses to group and/or individual* instruction tailored to meet their needs. Includes diabetes overview, nutritional counseling, home blood glucose monitoring, medication usage, prevention and treatment of acute and chronic complications, stress management, and behavior changes
☐ *Individual Program is indicated for the following reasons (check all that apply):
The following limitations will hinder effective participation in group training sessions:
☐ ESL ☐ Visually Impaired ☐ Hearing Impaired ☐ Low Literacy ☐ Impaired Cognitive/Psychosocial

☐ Follow-up to Comprehensive Program/Subsequent Year
☐ Insulin (Individual Training Session):
☐Type/Dose:_____ ☐ D/C Oral Meds: ☐ Yes ☐ No
☐ RN to Make Adjustments: ☐ Yes ☐ No
☐ Insulin Pump Program (Individual Training Sessions)
☐ Gestational/Pregnancy Program: EDC _____

5. PLEASE FAX A COPY OF OGTT AND OTHER PERTINENT LABS TO 617-243-5684.

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6. I certify that diabetes self-management training is needed under a comprehensive plan for this patient to manage his/her condition.

MD/NP Signature: _____ Date: _____

MD/NP Name (printed): _____ Phone: _____

7. **Forward completed form prior to visit to address above or FAX**: **617-243-5684**.

8. To schedule an appointment call 617-243-6144. **Please book appointments with BOTH the Diabetes Nurse and the Dietitian for newly diagnosed patients.**

This Form must be completed BEFORE the patient is seen in the Diabetes Management Program.