

**Saint Francis Medical Center
OUTPATIENT SERVICES REFERRAL FORM
Diabetes Education**

Name: _____	Date of Birth: ____/____/____
Primary Phone # _____	
Insurance: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other _____	
Ordering Physician: _____	

Interpreter Needed: Language: _____

Certificate of Medical Necessity for Diabetes Self-Management Training

1. Services Requested:

- Diabetes Self-Management and Medical Nutrition Therapy
Diabetes Educator, RN, CDE, (DSMT) up to 10 hours (can include class)
& Registered Dietitian, (MNT) up to 3 hours
- Diabetes Self-Management Only (DSMT)
Diabetes Educator, RN, CDE, up to 10 hours
- Medical Nutrition Therapy Only (MNT)
Registered Dietitian, up to 3 hours

2. Diagnosis:

- Type 1
- Type 2
- Gestational
- Pre-Diabetes (probable non-covered service)

3. Reason for Training:

- New Onset Diabetes -- Diagnosed within last 12 months/fasting BS \geq 126 mg on 2 occasions
- Recurrent -- Elevated fasting or random blood glucose levels are elevated
Hemoglobin A1C _____ result and date _____
- Change in Condition/treatment regimen:
 - Initiating oral diabetes medication: Name & dosage _____
- Insulin Start RX: Type: _____
Dose: _____
Time: _____
- Other _____

4. Monitoring:

Is patient currently monitoring Blood glucose? Yes No

Physician Signature: _____

Date: _____ Time: _____

† CATHOLIC HEALTH INITIATIVES



Well beyond healthcare.SM
2630 West Fairley Avenue
Grand Island, NE 68803

Saint Francis Medical Center Use Only
Account Number: F _____
Unit Number: H _____