Diabetes Self-Management Education Training Order Form

Patient Information

Last Name ____ First Name ____ Middle ____

Address ____ Phone Number ____

★ Diagnosis (Patient must have a diagnosis of diabetes)

- ☐ DM Type 2 (without complications) - E11.9
- ☐ DM Type 2 (uncontrolled) - E11.65
- ☐ DM Type 2 (with unspecified complications) - E11.8
- ☐ ____
- ☐ DM Type 1 (without complications) - E10.9
- ☐ DM Type 1 (with unspecified complications) - E10.8
- ☐ Gestational DM-024.419
- ☐ ____

Diabetes Self-Management Education/Training (DSME/T)

CHECK THE TYPE OF TRAINING SERVICES AND NUMBER OF HOURS REQUESTED

- ☑ Initial group DSME/T:
- ☐ Follow-up group DSME/T:
- ☑ 10 hours or number hours requested
- ☐ 2 hours or number hours requested

DSME/T CONTENT - CHECK OR WRITE IN

- ☑ Monitoring Diabetes
- ☑ Diabetes as Disease Process
- ☑ Psychological Adjustment
- ☑ Nutritional Management
- ☑ Goal Setting, Problem Solving
- ☑ Prevent, Detect, and Treat Acute Complications
- ☑ Medications
- ☑ Physical Activity
- ☐ Other *(Specific Training)* ____

★ Fax To: KTA Super Stores Puainako Pharmacy (808) 959-7559

Please attach:

- ☐ Most Recent Medication List
- ☐ Most Recent Notes on Diabetes Consultation
- ☐ Most Recent Labs
- ☐ Demographic Sheet

I certify that I am managing this patient's diabetes and that the diabetes self-management training requested is needed to provide the beneficiary with the skills and knowledge to self-manage the condition.

Signature ____ Date ____

NPI # ____

Group/Practice Name ____ Address ____ Phone Number ____

For questions or additional information, please call (808) 959-2888.

Revised 8/21/19 by Puna Plantation LTD dba KTA Puainako Pharmacy