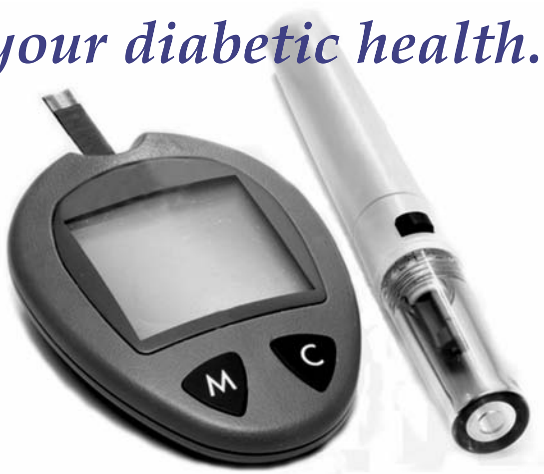
We are committed to your diabetic health.



Did you know?

- Most insurance plans will cover up to 10 hours of diabetic education in a 12-month period.
- In addition, your insurance plan may authorize three additional hours of diabetic education during the same 12-month period, with two additional hours every year thereafter. This is referred to as Medical Nutrition Therapy and is taught by a Registered Dietitian.
- A physician referral is required for insurance reimbursement. You will find a referral form inside this brochure for your physician to fill out and fax to the program coordinator for scheduling.
- The program offers group classes and individual counseling to help you gain better control of your health.
- **Please call 360-814-2184 for additional program information.**

Our program includes the following topics:

– Diabetes knowledge
– Meal planning
– Physical activity
– Monitoring blood glucose
– Medication management
– Insulin management
– Risk reduction
– Coping and problem solving

** Skagit Regional Health's Diabetic Education Program is certified by the American Diabetic Association and recognized by the Academy of Nutrition & Dietetics.*

MISSION STATEMENT

Skagit Regional Health believes that Diabetes Self-Management Education (DSME) will improve the delivery of health services and advance healthy outcomes for patients with diabetes.

1415 Kincaid Street
Mount Vernon
Washington 98274
360-814-2184

www.skagitvalleyhospital.org

S9123

DIABETIC EDUCATION PROGRAM

Your diabetes does not have to control you

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SKAGIT REGIONAL HEALTH
SKAGIT VALLEY HOSPITAL
SKAGIT REGIONAL CLINICS
Phone: 360-814-2184: FAX 360-814-5515

Diabetes Education Program Provider Referral Form (DSMT and MNT Services)

PATIENT INFORMATION

Patient Last Name:__________ First Name:__________ Middle:__________

Address:__________ City:__________ State:______ Zip Code:______

Birth Date:____/____/____ Gender: ❑ Male ❑ Female SS#:__________

Home Phone:__________ Work Phone:__________ Other Phone:__________

Primary Care Physician (if different):__________

Parent or Guardian:__________

Insurance Carrier:__________ Policy#:__________ Medicare HICN#:__________

Is Insurance Referral mandatory by PCP? ❑ Yes ❑ No

****IF INSURANCE REFERRAL IS MANDATORY, THE FOLLOWING ITEM MUST BE COMPLETED BEFORE PATIENT MAY BE ENROLLED IN PROGRAM****

Referral Authorization #:__________

DIAGNOSIS

Please fax progress notes and most recent HbA1c lab reports to substantiate diagnosis of diabetes/comorbidities

When diagnosed:__________ Prior diabetes education?: ❑ No ❑ Yes When?:__________

❑ **Please check box if you would like Diabetic Education Program staff to obtain HbA1c lab value.**

Diabetes self-management training (DSMT) and medical nutrition therapy (MNT) are individual and complementary services to improve diabetes care. For Medicare beneficiaries, both services can be ordered in the same year. Research indicates MNT combined with DSMT improves outcomes.

DIAGNOSIS

❑ Type 1 uncontrolled ❑ Type 1 controlled
❑ Type 2 uncontrolled ❑ Type 2 controlled
❑ Gestational diabetes ❑ Other

Complications/Comorbidities

Check all that apply:

❑ Hypertension ❑ Dyslipidemia ❑ Stroke
❑ Neuropathy ❑ Nephropathy ❑ PVD
❑ Renal disease ❑ Retinopathy ❑ CHD
❑ Non-healing wound ❑ Pregnancy ❑ Obesity
❑ Mental/affective disorder ❑ Other __________

DIABETES SELF-MANAGEMENT TRAINING (DSMT)

Medicare: 10 hours initial DSMT in 12 month period, plus 2 hours follow-up DSMT annually.

**Check type of training services and number of hours requested:*

❑ Initial group DSMT: ❑ 10 hours or
❑ Follow-up DSMT: ❑ 2 hours or
❑ Additional insulin training:

***Patients with special needs requiring individual DSMT**
Check all special needs that apply:

❑ Vision ❑ Physical ❑ CHD
❑ Cognitive impairment ❑ Pregnancy ❑ Obesity
❑ Language limitations ❑ Other __________

MEDICAL NUTRITION THERAPY (MNT)

Medicare: 3 hours initial MNT in the first year, plus tow hours follow-up MNT annually. Additional MNT hours available for charge in medical conditions, treatment and/or diagnosis.

**Check type of MNT and/or document number of additional hours requested:*

❑ Initial MNT ❑ Additional MNT services in the same calendar year; ______ additional hours requested per RD recommendation

Signature:__________ *Date____/____/____

Group/practice name, address and phone:__________

____

____

Contact Name/Phone:__________