**Diabetes Self-Management Education/Training and Medical Nutrition Therapy Services Order Form**

Name (Last, first, middle initial)  
MRN#  

Date of Birth ____/____/____  
Gender: ☐ Male ☐ Female  
Primary Language  
Insurance  

Address  
City  
State  
Zip Code  

Home Phone  
Other Phone  
Email Address  

**Diagnosis ICD – 10 Code: ______________**

<table>
<thead>
<tr>
<th>Diagnosis Description:</th>
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| □ Type 1 Diabetes  
□ Type 2 Diabetes  
□ Pre-diabetes  
Most Recent: □ A1c ____  
Date: _____________  | □ Gestational Diabetes  
□ Diabetes Complicated by Pregnancy  
TC ____  
LDL ____  
HDL ____  
Trig ____  
Date: _____________  |
| EDC _______________  
O’Sul _______________  
OGTT _______________  | □ Renal  
□ Obesity  
□ Other: ____________________________________________  |

**Diabetes Self-Management Education/Training (DSME/T)** can be ordered by MD, DO or ACP managing patient’s diabetes

Check type of training services requested:

- □ Initial Comprehensive DSME/T: maximum 10 hours in all 9 topics.  
  *If ordering Comprehensive please also order MNT for the dietitian to give an individualized meal plan*
  □ 10 hours or _______ # hrs. requested

- □ Follow-up DSME/T: maximum 2 hours after initial year
  □ 2 hours or _______ # hrs. requested

□ Management of Diabetes during Pregnancy/Gestational Diabetes Education

□ Injectable Training (name/dose) ____________________________________________

□ Insulin Pump Training

□ Personal Continuous Glucose Monitoring Training  
  ☒ Foot Clinic (Stanly only)

□ Professional Continuous Glucose Monitoring

□ Pre/Post Lipid and A1C may be performed if labs are not documented in Cerner or on referral form.

**Medical Nutrition Therapy (MNT)** must be ordered by MD or DO

- □ Initial MNT: maximum 3 hours initial year or per patient’s insurance and/or patient’s needs.
  □ 3 hours or _______ # hrs. requested

- □ Follow-up MNT: maximum 2 hours after initial year or per patient’s insurance and/or patient’s needs
  □ 2 hours or _______ # hrs. requested

**CHS Diabetes Prevention** (year-long program that meets 22 times-for those at risk for developing diabetes)

□ National Diabetes Prevention Program

**Indicate any barriers to group learning requiring individual (1 on 1) DSME/T**

Check all special needs that apply:

- □ Vision  
- □ Hearing  
- □ Physical  
- □ Cognitive Impairment  
- □ Language Limitations

□ Additional training  
□ Additional hrs. requested _____

Other: ________________________________________

Physician name/Practice name, address, and phone: ____________________________________________________________

**Signature ___________________________________________**  
NPI# ______________________  
Date _______/_____/______

**If DSMT – I hereby certify that I’m managing this beneficiary’s Diabetes Condition and the above prescribed training is a necessary part of management (Medicare patients).**
Carolinas HealthCare System Diabetes & Nutrition Centers

Carolinas HealthCare System Anson
email: DiabetesCenterCHSAnton@carolinashospitalcare.org
2301 US HWY 74 West
Wadesboro, NC 28170
Phone: 704-994-4522 | Fax: 704-994-4501 (Alternate Fax 704-994-4701)

The Diabetes Center at Carolinas HealthCare System Lincoln
CHS Lincoln Medical Plaza 1
441 McAlister Road
Lincolnton, NC 28092
Phone: 980-212-6046 | Fax: 980-212-6038

Carolinas Diabetes Center@ Carolinas HealthCare System Main
1025 Morehead Medical Dr. Suite 500 (Morehead Medical Plaza I )
Charlotte, NC 28204
Phone 704-446-2320 | Fax: 704-446-2321 (Alternate Fax 704-446-2335)

The Diabetes and Nutrition Center @ Carolinas HealthCare System NorthEast
130 Lake Concord Road
Concord, NC 28025
Phone 704-403-3543 | Fax: 704-403-3572

Disease Management | Health Promotion @ Carolinas HealthCare System Stanly
313 Yadkin Street
Albemarle, NC 28001
Phone 980-323-4189 | Fax: 980-323-5162

The Diabetes and Nutrition Center at Carolinas HealthCare System Union
600 Hospital Drive
Monroe, NC 28111
Phone 980-993-2880 | Fax: 980-993-2881 (or 980-993-5752 alternate Fax #)