HOUSTON Methodist LEADING MEDICINE

Physician Order Form
Diabetes Self-Management Education &
Medical Nutrition Therapy

***Indicates Required Information for Medicare patients**

PREFERRED LOCATION & DEMOGRAPHICS

☐ Baytown ☐ Clear Lake ☐ Sugar Land ☐ Texas Medical Center ☐ The Woodlands ☐ West ☐ Willowbrook

SCHEDULING PHONE NUMBER: 713.441.5975 | FAX: 713.790.6366

PATIENT'S NAME	DATE OF REFERRAL	DATE OF BIRTH	SEX M F
PRIMARY PHONE	ALTERNATE PHONE	PATIENT ADDRESS	
PATIENT INSURANCE			

COMPLETE ALL PERTINENT DIAGNOSIS ICD 10 CODES

Type 1 diabetes	E10._____	Obesity	E66._____	Thyroid	____.___
Type 2 diabetes	E11._____	Metabolic syndrome	E88._____	GI	____.___
Other diabetes	E13._____	Hypertension	I10. _____	Liver	____.___
Impaired or abnormal glucose	R73._____	High cholesterol	E78._____	Cancer	____.___
Gestational diabetes	O24._____	Renal	N18._____	Other	____.___

*DIABETES EDUCATION: Complete entire section below if referring for diabetes self-management education (DSME)

1. Check type of services needed and number of hours requested:
   - ☐ Initial comprehensive diabetes education — up to 10 hours and all nine American Diabetes Association core topics
   - ☐ Follow-up education — up to 2 hours
   - ☐ Specific topics and hours, if needs vary from above: _____

2. Indicate any special needs requiring individual or customized education:
   - ☐ Language
   - ☐ Literacy
   - ☐ Vision, hearing or physical
   - ☐ Carbohydrate-to-insulin ratio education
   - ☐ Insulin training
   - ☐ Pump overview
   - ☐ Recent organ transplant
   - ☐ Other _____

With my signature below, I hereby certify that I am managing this patient's diabetes condition and that the above prescribed training is a necessary part of management.

MEDICAL NUTRITION THERAPY (MNT) & INTENSIVE BEHAVIORAL THERAPY (IBT)

Check type of service(s) requested:

☐ Nutrition consultation (IBT/MNT per dietitian's discretion) ☐ Weight loss programs

LABS

Attach recent lab work and progress notes.

REFERRING PHYSICIANS

Additional Instructions

Physician's Name and Address	Physician NPI	**Contact for Questions**
		Contact Name: _____
Physician's Signature	Date and Time	Phone: _____
		Fax: _____