Massachusetts General Hospital/Massachusetts General Physician Organization Diabetes Self-Management Education (DSME) Program Patient Order Form

			Γ	Date of birth:_		
Medical	Record Number:					
Diagn	osis:	_	0	.0)		
	Type 2 diabetes (250.00)		Gestational diabetes (648			
	Type 1 diabetes (250.01)		Other: (Use $250.1 - 250.8$ for diabetes	i		
			w/complications)			
Comp	licating Conditions:		W/CIIIIIIIII AIIIIIXI			
	HTN		Neuropathy			
	Dyslipidemia		Other			
	Nephropathy					
Reaso	n(s) for Referral:					
	New onset diabetes		Frequent or severe		Elevated HgbA1c	
	Pre-pump evaluation		hypoglycemia		Assess/change treatment	
	Uncontrolled diabetes		1	es \Box	Other:	
	Frequent or severe hypoglycemi		Pre-pump evaluation			
Services Requested: Please check the boxes below that pertain to your patient:						
☐ Comprehensive DSME Program						
		(G	0108 & GO109)			
□ Initia	al DSME:					
All patients receive an initial individual assessment by a Certified Diabetes Educator (CDE) or CDE eligible provider.						
	ay progress to up to an additional 9 ho					
content a	reas as required by the American Diabo	etes As	sociation (ADA) and is conti	nuous within a I	2-month period.	
Number	of Hours Ordered:					
	Individual					
	Group					
Individu	alized Education is Necessary due	to:				
	emotional challenges					
	Patient needs additional insulin ins	tructi	on			
	Other (please specify)					
□ Follo	ow-up DSME (subsequent year, 2 I	hours	only)			
Number	of Hours Ordered:					
					I	
	trictions regarding exercise					
If none,	please initial here for medical cle	arano	e for exercise			
I hereby	state that the above ordered treatm	ent is	medically necessary and	is an inteoral n	part of	
I hereby state that the above ordered treatment is medically necessary and is an integral part of comprehensive care for my patient.						
Date: Physician's signature:						
Physician address (non-MGH physician						
only)						
Physicia	n telephone (non-MGH physician					
only)						