Health Partners – Referral for ABC Diabetes Self-Management Education

Please circle one: English / Spanish

ACHIEVING BETTER CONTROL® INC.
CLINICAL SELF-MANAGEMENT PROGRAMS

R_x

I am referring _____ Date of Birth: _____

Phone (daytime): _____ Evening: _____

Diagnosis (Please indicate):

☐ 250.00 – Diabetes type 2, controlled	☐ 250.01 – Diabetes type 1, controlled
☐ 250.02 – Diabetes type 2, uncontrolled	☐ 250.03 – Diabetes type 1, uncontrolled

❒ **COMPREHENSIVE DIABETES SELF MANAGEMENT PROGRAM**

DSME: (10 hours GROUP) program includes:

- Individualized assessment
- Overview of the disease process
- Medication Management
- Nutrition
- Monitoring blood glucose and ketones and use of results to improve control
- Prevention, detection, and treatment of acute complications
- Prevention, detection, and treatment of chronic complications
- Physical activity
- Psychosocial adjustment
- Goal setting and problem solving in daily living
- Diabetes Self-Management Support Planning

Medical Nutrition Therapy – (4-6 hours GROUP)

❒ **Diabetes Self Management Education follow up – (2- 6 hours GROUP)**

❒ **INSULIN INITIATION: attach copy of prescription – (Individual)**

NOTE: Please provide most recent A1C, if available, or most recent lab results.

A1C result: _____ Date: _____ Pending: ☐

I certify that I am managing the beneficiary's diabetic condition and that the services described above are medically necessary under a comprehensive plan of care related to the beneficiary's diabetic condition to ensure therapy compliance and to help manage the beneficiary's diabetes.

Physician's Name (printed): _____ NPI: _____

Physician's Signature: _____ Date: _____

Phone number: _____ Fax: _____

OFFICE STAFF PLEASE FAX TO 215-283-1919