Diabetes Self-Management Education Referral Form

West Towne Pharmacy
1619 West Market St ● Johnson City, TN ● 37604 ● P (423) 926 - 9137 ● F (423) 926 - 7321

Patient Name: _____ DOB: ____/____/____ Gender: ____ Male ____Female
Address: _____
Phone: _____ Social Security #: _____ Insurance: _____

Diabetes self-management education (DSME) is used to enhance patients' knowledge about diabetes. We seek to target barriers of optimal self-care and work with patients to overcome these barriers and empower them to make healthier decisions at home. As a part of the program, we will maintain communication via fax or phone of patient progress, goal-setting, etc. Most insurance companies cover 10 hours of initial DSME for patients with diagnosed diabetes mellitus and 2 hours of annual follow-up.

DSME Requested:		**Reason for Requiring 1-on-1 DSME:**	
Initial Group DSME: _____ 10 hours Initial 1-on-1 DSME: _____ 10 hours Annual Follow-up DSME: _____ 2 hours Annual Follow-up 1-on-1 DSME: _____ 2 hours		____ Vision ____ Cognitive Impairment ____ Hearing ____ Language Limitations ____ Physical ____ Other: _____	
Diagnosis:	____ T1DM ____ T2DM	**Most Recent A1c:**	_____
ICD-10 Code:	_____	**Date of A1c:**	_____
DSME Content:			
____ Monitoring Diabetes ____ Diabetes as a disease process ____ Psychological Adjustment ____ Physical Activity ____ Nutritional Management ____ Goal Setting, Problem Solving ____ Medications ____ Managing Acute Complications ____ Preventing Chronic Complications			
Complications & Comorbidities:			
____ Hypertension ____ Dyslipidemia ____ Stroke ____ Neuropathy ____ PVD ____ CHF ____ CKD ____ Retinopathy ____ Obesity ____ Non-healing wound ____ Pregnancy ____ Mental/affective d/o ____ Other: _____			

Provider Name: _____ NPI: _____ Practice: _____
Address: _____
Phone: _____ Fax: _____
Signature: _____ Date: ____/____/____

Please fax the completed form to 423-926-7321. Please include copies of the patient's insurance cards.