MEDICAL NETWORK ONE
Michigan Institute For Health Enhancement

DIABETES SELF-MANAGEMENT EDUCATION (DSME)
MEDICAL NUTRITIONAL THERAPY (MNT)
REQUEST FORM

Phone number: 866-648-3265 or 248-475-4880 Fax number: 248-475-4881 E-mail: info@miteam.org

PATIENT INFORMATION

Patient's last name:	First:		Middle:
Gender: ❑ Male ❑ Female	DOB: / /	Health Plan:	ID #:
Street address:		Home phone number: ( )	Work/Cell number: ( )
City:	State:		ZIP Code:

DIAGNOSIS	**DIABETES SELF-MANAGEMENT EDUCATION**
(Please send recent labs for outcomes evaluation)	(Check types of education being ordered)
❑ Diabetes Type 1 controlled ❑ Diabetes Type 1 uncontrolled ❑ Diabetes Type 2 controlled ❑ Diabetes Type 2 uncontrolled ❑ Gestational Diabetes ❑ Other:	❑ Initial training Patient has special need(s) to receive individual instruction (Check all that apply) ❑ Vision ❑ Hearing ❑ Physical ❑ Cognitive Impairment ❑ Language Limitations ❑ Other: ❑ Follow-up training

Diabetes Self-Management Education (DSME) and Medical Nutrition Therapy (MNT) are services to improve diabetes care.

COMPLICATIONS/COMORBIDITIES: (CHECK ***ALL*** THAT APPLY)			**MEDICAL NUTRITION THERAPY:** Provided by the Registered Dietitian (RD)
❑ Hypoglycemia ❑ Hyperlipidemia ❑ Hypertension ❑ Non Healing Wound ❑ Chronic Depression ❑ Chronic Pain ❑ Other:	❑ Pre-diabetes ❑ Renal Disease ❑ Retinopathy ❑ Neuropathy ❑ Asthma	❑ Stroke ❑ CAD ❑ CHF ❑ COPD ❑ Obesity	❑ Initial MNT ❑ Annual Follow- up MNT ❑ Additional MNT services in the same calendar year, per RD recommendations Please specify any changes in diagnosis, medical condition or treatment regimens:

LIST MEDICATIONS:	**RESULT:**
(Specify type, dose, frequency)	❑ A1C _____ ❑ Foot Exam _____ ❑ B/P _____ ❑ Ret. Eye Exam _____ ❑ LDL _____ ❑ HDL _____ ❑ CHOL _____ ❑ TG _____

SIGNATURE & NPI:	**DATE:**
PRACTICE NAME:	
ADDRESS:	**PHONE: ( ) -**