KONTOSNUTRITION

Nutrition Therapy – Diabetes Education – Medical Fitness – Sports Nutrition – Wellness

Referral Form for Diabetes Self Management Education /Training (DSME/T) & Medical Nutrition Therapy (MNT)

***Fax** this form to KontosNutrition at: 212-865-0788 **Or call** to schedule the appointment at: 212-865-0788*

Patient Information

Patient's Last Name ______ First Name ______ Middle------------------

Date of Birth _______/_______/_______ Gender: ☐ Male ☐ Female

Address ______ City ______ State ______ Zip Code-------------

Home Phone: ______ Other Phone: ______ E-mail address--------------------------

Diabetes self-management education and training (DSME/T) and medical nutrition therapy (MNT) are individual and complementary services to improve diabetes care. Both services can be ordered in the same year.

Diabetes Self-Management Education/Training (DSME/T)

Check type of training services and number of hours requested

☐ Initial DSME/T: 10 hours or ____ no. hrs. requested

☐ Follow-up DSME/T: 2 hours or ____ no. hrs. requested

Patients with special needs requiring individual (1 on 1) DSME/T

Check all special needs that apply:

☐ Vision Hearing Physical

☐ Cognitive Impairment Language Limitations

☐ Additional training additional hrs requested ___________

DSME/T Goals:

Monitoring diabetes. Diabetes as disease process
Psychological adjustment. Physical activity
Nutritional management. Goal setting, problem solving
Medications Prevent, detect and treat acute complications
Preconception/pregnancy management or GDM
Prevent, detect and treat chronic complications.

Medicare coverage: 10 hrs initial DSMT in 12 month period from the date of first class or visit

DIAGNOSIS

☐ Type 1 ☐ Type 2 ☐ Gestational

ICD 10 Code______________________________________

Please send recent labs for patient eligibility & outcomes monitoring

Complications/Comorbidities. *Check all that apply:*

Hypertension, Dyslipidemia, Stroke, Neuropathy, PVD, Kidney disease, Retinopathy, CHD, Non-healing wound, Pregnancy, Obesity, Other: _______________________________

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Medical Nutrition Therapy (MNT)

Check the type of MNT and/or number of additional hours requested

Initial MNT 3 hours or ____ no. hrs. requested

Annual follow-up MNT 2 hours or ____ no. hrs. requested

Additional hrs. requested _______________

Please specify change in medical condition, treatment and/or diagnosis:

ICD 10code(s):__________________________

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Medicare coverage of DSMT and MNT requires the physician to provide documentation of a diagnosis of diabetes based on one of the following:

- A fasting blood sugar greater than or equal to 126 mg/dl on two different occasions;
- A 2 hour post-glucose challenge greater than or equal to 200 mg/dl on 2 different occasions; or
- A random glucose test over 200 mg/dl for a person with symptoms of uncontrolled diabetes.

Other payors may have other coverage requirements.

Medicare coverage: 3 hrs initial MNT in the first calendar year, plus 2hrs follow-up MNT annually. Additional MNT hours available for changing medical condition, treatment and/or diagnosis.

Signature and NPI # ______________________________________ Date _______/_______/_______

Group/practice name, address and phone: ______________________________________

Spiros Kontos MS, RD, CDN, CDE

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