

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

Name: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Medical Record Number: \_\_\_\_\_

**Diagnosis:**

- Type 2 diabetes (250.00)
- Type 1 diabetes (250.01)
- Gestational diabetes (648.8)
- Other: (Use 250.1 – 250.8 for diabetes w/complications)

**Complicating Conditions:**

- HTN
- Dyslipidemia
- Nephropathy
- Neuropathy
- Other \_\_\_\_\_

**Reason(s) for Referral:**

- New onset diabetes
- Pre-pump evaluation
- Uncontrolled diabetes
- Frequent or severe hypoglycemi
- Frequent or severe hypoglycemia
- Complications of diabetes
- Pre-pump evaluation
- Elevated HgbA1c
- Assess/change treatment
- Other: \_\_\_\_\_

**Services Requested: Please check the boxes below that pertain to your patient:**

**Comprehensive DSME Program**

**(GO108 & GO109)**

**Initial DSME:**

*All patients receive an initial individual assessment by a Certified Diabetes Educator (CDE) or CDE eligible provider. Patient may progress to up to an additional 9 hours of instruction, based on need. This program contains the 10 curriculum content areas as required by the American Diabetes Association (ADA) and is continuous within a 12-month period.*

**Number of Hours Ordered:** \_\_\_\_\_

- Individual
- Group

**Individualized Education is Necessary due to:**

- Vision, hearing, language, physical, or emotional challenges
- Patient needs additional insulin instruction
- Other (please specify)

**Follow-up DSME (subsequent year, 2 hours only)**

**Number of Hours Ordered:** \_\_\_\_\_

**Interpreter services needed: (type)** \_\_\_\_\_

**Any restrictions regarding exercise** \_\_\_\_\_

**If none, please initial here for medical clearance for exercise** \_\_\_\_\_

**Any other complicating conditions:** \_\_\_\_\_

*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) \_\_\_\_\_

Physician telephone (non-MGH physician only) \_\_\_\_\_