Clinical Diabetes Management Program referral

Patient name:_____

Patient's date of birth: _____

Phone number: _____

Email address: _____

PCP: _____

PCP phone number: _____

Recent HgbA1c (if available):_____

Criteria for referral:

☐ Diabetes with any hospital admit in past year

☐ Anyone with a A1c > 9%

☐ Anyone with diabetes and PVD/PAD

☐ Anyone with diabetes and CKD 3B or worse

☐ Any significant co-morbidities along with diabetes

☐ Anyone newly diagnosed with diabetes

☐ Anyone you feel has complicated diabetes or would benefit from the program

Include any additional information you feel they should have:

_____

_____

_____

_____

Any concerns you may have (social or etc.):

Fax referral: **1-855-268-9394** or call: **1-623-293-9998,** TTY **711**

Thank you so much for your kind referral.
We look forward to helping your patient's live healthier lives.