PATIENT REFERRAL FORM

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PATIENT INFORMATION				REFERRER INFORMATION	
*NAME:				*NAME:	
*ADDRESS:				ADDRESS:	
				*TEL NO:	
*GENDER:		*D.O.B:	| |	FAX NO:	
*EMAIL:				**PATIENT INSURANCE INFORMATION**	
*PHONE #:	( )			*PRIMARY INSURED:	
TYPE 1 ☐	TYPE 2 ☐	PRE DIABETIC ☐	METABOLIC DISORDER ☐	*GROUP #:	
CURRENT DM REGIMEN:	DIET ☐	ORAL ☐	ORAL + INSULIN ☐	*INSURANCE NAME:	
	PUMP ☐	INSULIN ☐			
INTERPRETER REQUIRED:	YES ☐	NO ☐	LANGUAGE:	*MEMBER ID:	
				*PHONE #:	

BIOMEDICAL RESULTS – MOST RECENT			REASON FOR REFERRAL – MARK ALL THAT APPLY		
TEST	LAST RESULTS	DATE	*COMPLICATION	*YES/NO?	ICD 10 CODE
*HgbA1c			FATIGUE	YES NO	
Fasting Blood Sugar			NEUROPATHY	YES NO	
CHOLESTEROL			RETINOPATHY	YES NO	
TRIG			NEPHROPATHY	YES NO	
HDL			HYPERTENSION	YES NO	
LDL			OBESITY	YES NO	
BUN			ERECTILE DYSFUNCTION	YES NO	
CREATININE			DIABETIC ULCER	YES NO	
eGFR			AT RISK AMPUTATION	YES NO	
URINALYSIS			SLEEP DISORDER	YES NO	
VITAMIN D			DEPRESSION	YES NO	
MAGNESIUM			UNCONTROLLED BLOOD SUGAR	YES NO	

ADDITIONAL NOTES

*PRINT NAME:	*SIGNATURE:	*DATE:

COMPLETED FORM SUBMISSION
FAX: (281) 215-5008

* Indicates required field

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