



## 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:

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### 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.

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