



The Diabetes Bus Initiative[®]

The 501c3 nonprofit home of: Diabetes Management Solutions

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Referral to Insulin Start Class

Please be aware that this class could be scheduled up to 3 weeks from referral, so it should not be used for acute need. We highly recommend that you refer the patient to our diabetes self-management classes at the same time.

Date: _____ **Provider Name:** _____ (or stamp)

Patient Name: _____ **DOB:** _____

Patient Address: _____
(street, city, zipcode)

Patient Home Phone: _____ **Day/Cell Phone:** _____
(please include area code)

Provider Use:

Instruction for: (check one)

Insulin Pen _____

Insulin Vial/Syringe _____

Byetta/Symlin _____

Recent Hgb A1c: _____ (result/date)

Insulin/ Meds Dose: _____

Make sure patient has prescription filled

Additional Instructions/Comments: _____

***All bolded info must be complete for us to schedule the patient for instruction**

Please include cover sheet. Fax to: 919-876-8465. Thank you.