



The Diabetes Bus Initiative ®

The 501c3 nonprofit home of: Diabetes Management Solutions
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Referral to Diabetes Self- Management Classes

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

Patient Name: _____ **DOB:** _____

Patient Address: _____
(street, city, zip)

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

Provider Use:

Diabetes Diagnosis: (check one) **Recent Hgb A1c:** _____ (result/date)
Type 2 _____ (>126 fasting) (this data is vital for grants, lab sheet is OK)
Type 1 _____
Pre-diabetes: _____ (>100 fasting)

Comments/Concerns: _____

Provider Signature: _____

***Please include cover sheet. Information must be complete!
We do NOT need insurance info. Fax to: 919-876-8465. Thank you.***