



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

Home Phone: () _____ - _____ Day/Cell Phone: () _____ - _____

Provider Use:

Diabetes Diagnosis: (check one)

___ Pre-diabetes (>100 fasting)

___ Type 2 (>126 fasting)

___ Type 1

controlled

uncontrolled

controlled

uncontrolled

Recent Hgb A1c: _____ (result/date) (this data is vital for grants, lab sheet is OK)

Complications/Comorbidities: (check all that apply)

Hypertension

Dyslipidemia

Stroke

Retinopathy

Neuropathy

Nephropathy

Renal Disease

CHD

Obesity

Other _____

Current Diabetes Medications:

	Name	Dose	Frequency
Oral	_____	_____	_____
	_____	_____	_____
Insulin	_____	_____	_____
	_____	_____	_____

Special needs for this patient:

Vision

Hearing

Physical

Cognitive impairment

Language

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.