Diabetes Care Program
Self Referral Form

<u>To attend our clinic you must be:</u>

-Over the age of 18 years of age
- Have a confirmed diagnosis of Pre-diabetes or Type 2 diabetes
- Be a resident of East Wellington

<u>Please fill out the following information and drop it off at one of our clinics.</u>
If possible, please attach recent blood work results and an up to date medication list.

****By completing and signing this form you are giving our clinic permission to contact your doctor for more information if it is required****

Name: ______________________________ Male Female
Home phone: ________________________ Work/Cell phone: _________________
Address: ____
Email address: ____
Date of birth: ________________________ HCN: _____________________________
Family Doctor: _______________________ Phone number: ____________________
Name of the pharmacy you use: ____

Do you have? Pre-diabetes Diabetes
How long have you had diabetes? ____________
Do you have any allergies? Yes No
If yes, what are your allergies? ____
Is there anything you would like to tell us about yourself?

When is the best time to contact you? __________________

When is the best time for appointments? Daytime Evening

Patient signature: ____________________ Date: __________________

Thank you for submitting this self-referral sheet. We are looking forward to meeting with you and will contact you soon!

October 2012