Community Diabetes Project/
Proyecto Comunitario de la Diabetes

CLASS REFERRAL FORM
Please Fax back to (408)289-9464

Referral Date/Fecha del Referido: _____ /_____ /_____

REFERRAL FOR:

- ⬭ Spanish Diabetes Self-Management Classes (Adult/Type 2/Spanish-speaking or bilingual)
- ⬭ English Living with Chronic Conditions Classes (Adult/Chronic Condition/English or bilingual)

I. REFERRAL SOURCE / REFERIDO POR:

- ⬭ Self / Por sí mismo
- ⬭ Nonprofit Agency / Agencia Communitaria
- ⬭ Hospital or Health Center / Hospital o Clínica
- ⬭ Private Doctor / Doctor particular
- ⬭ Insurance Co. / Seguro médico
- ⬭ Gov. –sponsored plan / Seguro del Gobierno

Agency / Agencia: _____

Representative / Representante: _____ Phone: _____

II. PATIENT INFORMATION / INFORMACION DEL PACIENTE:

Most Recent HBA1c:

Patient / Chart ID#: _____ (your main patient identifier) _____ Date: _____

Nombre/Name: _____ M___ F___ Fecha Nacimiento/DOB: _____

Domicilio/Address: _____
(Número/Number) (Ciudad/City) (Código postal/Zip code)

Insurance / Seguro Médico: _____

Doctor: _____

Community Health Center / Clínica _____

Home Ph./Tel. Casa: _____ Work Phone / Tel. Trabajo: _____

Cellular / Celular: _____ Fax #: _____

E-mail Address: _____

Languages/Idiomas: ⬭ Spanish ⬭ English