



"A partnership for better living"

Health Education Alliance

3100 Edgewood Road
Eureka, CA 95501

Diabetes and Health Education Referral Form

Fax Completed Form to 707-443-2527

707.443.0124

www.healhdnpa.com

MRN/Chart #: _____	
Patient's Name: _____	Date of Birth: _____ Gender: M F
Best Contact Phone: _____	Insurance: _____
Patient Address: _____	
Referring Clinician: _____	
Referring Practice: _____	
Practice Phone: _____	Practice Fax: _____

Diagnosis: Type 1 Diabetes Type 2 Diabetes Gestational Diabetes

Morbid Obesity Metabolic Syndrome Other _____

Is the patient currently on insulin? Yes No

Referral is for: Education only/Nutrition Insulin start per protocol Insulin management

Primary Language: English Spanish Other: _____

Other Comments Regarding the Patient's Needs: _____

An HbA1c will be ordered after the last class on your behalf with a copy sent to you unless you check this box.

Clinician's Signature: _____ Date _____

REQUIREMENTS: MOST CURRENT LAB RESULTS, INSURANCE CARD & CHART NOTE

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