EDC
Everyone with Diabetes Counts

Diabetes Empowerment Education Program (DEEP)
Referral for Diabetes Education

_____ _____ ____ _____

Patient's Last Name **Patient's First Name** **MI** **Medicare #**

____ / ____ / 19____ **Gender:** ☐ Male ☐ Female

Date of Birth

Race
- ☐ African-American
- ☐ Hispanic/Latino
- ☐ Asian/Pacific Islander
- ☐ American Indian/Alaska Native
- ☐ any race/ethnicity (rural areas)

_____ _____

Telephone # **Alternate Telephone #**

_____

Address/Apartment #

_____ _____ _____ _____

City **State** **Zip Code** **County**

_____ _____ _____

Provider/Clinician **NPI#** **Facility/Group Name**

Complete the applicable boxes (HbA1c, Lipid, BP). Circle the Y/N for Other Exams. Write the Wt/Ht/BMI.

Timeframe	HbA1c	LDL-C	BP Systolic	BP Diastolic	Other Exam	Wt/Ht/BMI
Referral Date: ___/___/___	Date ___/___/___ Value _____	Date ___/___/___ Value _____	Date ___/___/___ Value _____	Date ___/___/___ Value _____	Foot Exam Y | N Date ___/___/___ Eye Exam Y | N Date ___/___/___	Date ___/___/___ Weight _____ Height _____ BMI _____

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Diabetes Complications: ☐ Yes ☐ No *If yes, please provide comments below.*

_____

_____

_____

_____

Barriers to Learning/Participation:

☐ **Sight** ☐ **Mobility**

☐ **Hearing** ☐ **Other (specify):**

☐ **Literacy** _____

☐ **Transportation** _____

Completed by: _____ **Date:** _____

Staff Member Name

Notes:

_____

_____

_____

_____

_____

_____

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atom Alliance for Powerful Change

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