



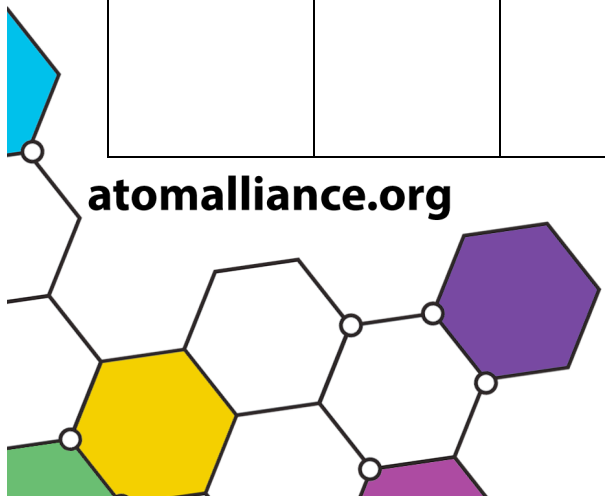
Diabetes Empowerment Education Program (DEEP) Referral for Diabetes Education

Patient's Last Name	Patient's First Name	MI	Medicare #
____ / ____ / 19____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race: <input type="checkbox"/> African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> any race/ethnicity (rural areas)	
Date of Birth			
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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