inspire HEALTH MEDICAL GROUP **ENDOCRINOLOGY**

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DEAP
Diabetes Education Accreditation Program
AADE American Association of Diabetes Educators

FAX REFERRAL FORM

Date: ______________________ Number of Pages: ______________________

☐ *First Available*
☐ Varsha Babu, MD
☐ Shreela Mishra, MD
☐ Tulsi Sharma, MD
☐ Elsa Carrillo, RDN
Registered Dietician Nutritionist
☐ Diabetes Class

Patient Name: ______________________ DOB: ______________________

Patient Home Phone: ______________________ Patient Cell: ______________________

Diagnosis (required):______________________

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Referring Physician: ______________________

Phone: ______________________ Fax : ______________________

PCP (if different from referring): ______________________

Insurance: ______________________

REQUIRED PATIENT INFORMATION All information below is needed to schedule an appointment.

☐ Referral (*Must include HMO referral for appointment to be scheduled.)*
☐ Patient insurance card and demographics
☐ Last chart notes, H & P
☐ Last lab results/CT reports (must have at least 1) (If Applicable)
☐ Medication list
☐ Last lab results/Spirometry/ECHO (If Applicable)

Thank you very much for referring your patient to our office.

OFFICE USE ONLY:

Appointment Date at UDES: ______________ Time: ______________ with Dr.: ______________________

☐ Unable to contact - **Referral Closed** ______________________

05.13.24