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
- ☐ Leonid Vydro, MD
- ☐ Elsa Carrillo, RDN
  Registered Dietician Nutritionist
- ☐ Diabetes Class

Patient Name: _____ DOB: _____

Patient Home Phone: _____ Patient Cell: _____

Diagnosis (required):_____

_____

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/Ultrasound reports (must have at least 1) (If Applicable)
- ☐ Medication list

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** _____