This product was developed by the diabetes self management project at Gateway Community Health Center, Inc. in Laredo, TX. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.

GATEWAY COMMUNITY HEALTH CENTER, INC.

Main Clinic
2309 E. Saunders

South Clinic
2007 S. Zapata Hwy.

Laredo, TX
(956) 795-8100

Referral Form

DATE: _____/_____/_____ **ID#** _____ **Course Date:**

CLIENT NAME: _____ **PHONE:** _____

ADDRESS _____ **DOB:** _____/_____/_____

APPROXIMATE NUMBER OF YEARS WITH DIABETES _____ **TYPE OF DIABETES: Type 1 or Type 2**

SEX: ☐**Male** ☐**Female** **LANGUAGE:** ☐**English** ☐**Spanish** **Educational Level** _____

Patient is being referred to Gateway Community Health Center for a ten week Diabetes Self Management Course and follow-up which will be conducted through Diabetes Support Groups.

Patient Clinical Information

HbA1c: _____ Date_____ Foot Examination: No_____ Yes_____ Date_____

Lipid Profile: _____ Date: _____ Smoking Status: Smoker_____ Non-Smoker_____

Blood Pressure: _____Date: _____ Health Insurance: Yes_____ No_____

In the past year, has the patient visited the hospital/ER for diabetes related complications? Yes_____ No ___

If Yes, Number of visits to Hospital ____ Length of stay? _____ Number of Emergency Room visits_____

Signature of Physician: _____ Date: _____

I hereby authorize the referring and/or receiving agencies that attend to my medical needs to disclose, when requested to do so, information with respect to my diabetes or follow-up status. I acknowledge that Patient Clinical Information will be requested from the physician prior to sessions and at six and twelve months after the completion of course. I also waive any and all claims and/or liability against Gateway Community Health Center, Inc. or any of its Board of Directors, volunteers, or employees for any services provided.

Yo doy la autorización a esta agencia y a la agencia a la cual soy referido(a) para proveer información referente a mi diabetes o seguimiento, si así es requerido. Comprendo que mi información clinica se le pedira al medico al empezar, a los seis y a los doce meses después de los cursos. También renuncio por este medio a cualquier y a todos los reclamos, en contra de Gateway Community Health Center, Inc., los Miembros de la Mesa Directiva, voluntarios o empleados por servicios.

Signature of Patient: _____ **Date:** _____