



GATEWAY COMMUNITY HEALTH CENTER, INC.

Main Clinic
2309 E. Saunders

Laredo, TX
(956) 795-8100

South Clinic
2007 S. Zapata Hwy.

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 clínica se le pedirá 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: _____

