A New DEAL Diabetes Program
Florida Department of Health in Duval
Division of Nutrition and Chronic Disease Prevention
900 University Blvd. N., Suite 606
Tel. (904) 253-1800 Fax. (904) 253-2450

CALL (904) 253-1800 TO REGISTER

Diabetes Class Referral Form

Patient's Name: _____ DOB: _____

Patient's Phone #: _____

Patient's Address: _____

_____

Referred by (Doctor's name): _____
(Please print legibly)

Practice/Clinic: _____ Phone #: _____

Address: _____ Fax #: _____

Please fill out the following information regarding the patient:

Diagnosed with (please check one):

☐ Pre-diabetes ☐ Type 1 Diabetes ☐ Type 2 Diabetes

AIC: _____ Date _____

Blood Pressure: _____ Date _____

Cholesterol: Total: _____ Flu Shot Date: _____

HDL: _____ Eye Exam Date: _____

LDL: _____ Foot Exam Date: _____

Date: _____ Height: _____ Date: _____

Weight: _____ Date: _____

1 – By accepting this referral to A New DEAL, your patient also grants our program staff the right to obtain follow-up laboratory results as listed on this referral document: Hemoglobin AIC, Cholesterol levels (total, HDL and LDL) as well as weight and blood pressure records.

2 – By referring your patient to A New DEAL, you, the provider, are making a commitment that your office staff will be cooperative in pulling the above-mentioned information upon request for adequate follow-up purposes. All releases as they relate to the Health Insurance Portability and Accountability (HIPAA) should be completed, signed and kept on file by your office.

_____ _____
Patient's Signature Date

_____ _____
Parent/Legal Guardian Signature (if patient <18) Date

_____ _____
Referring Provider's Signature Date

For Use by Program Staff Only: (INI:)

Patient registered on:

Patient attended/completed DSME on:

Lab follow up received from doctor/patient within 6 months: Y N