



*Down East*  
**DIABETOLOGY**

*Diabetes Practice for Children, Young Adults and Diabetes in Pregnancy*

www.DownEastDiabetology.com

2609 West Arlington Blvd., Suite 106

Greenville, NC 27834

Phone: 252-689-6303

Fax: 252-689-6304

Electronic Fax: 855-739-9145

We appreciate this referral. Please complete the top half of this form and fax to (252) 689-6304. We will gladly contact the patient, schedule the appointment and fax this completed form back to you.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

(If under 18 y.o.) Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Numbers: (cell) \_\_\_\_\_

(home) \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Email: \_\_\_\_\_

(For Medicaid, NPI: \_\_\_\_\_)

# of Authorized Visits: \_\_\_\_\_)

Type of Diabetes:

Prediabetes

Type 1 Diabetes

Type 2 Diabetes

Gestational Diabetes

Unknown or New Onset

Referring Provider Name:

Referral Coordinator Name: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Practice Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Office notes will be sent to the referring provider promptly after the  
clinical visit.

---

**To be completed by Down East Diabetology and faxed back to the  
referring office:**

Scheduled Patient Appointment Time: \_\_\_\_\_

Patient notified by: \_\_\_\_\_

Phone call on: \_\_\_\_\_

Letter mailed on: \_\_\_\_\_

Referring provider office notified on: \_\_\_\_\_

Thank you for this referral.