Down East DIABETOLOGY

Diabetes Practice for Children, Young Adults and Diabetes in Pregnancy

www.DownEastDiabetology.com
845 Johns Hopkins Dr., Suite B
Greenville, NC 27834
Phone: 252-689-6303
Fax: 252-689-6304

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.