FAX REFERRAL FORM

Referral Date: _____

Physician Name: _____

Practice Name: _____

Phone #: _____

Email: _____

Diabetes Prevention and Control Programs

(Please print clearly)

Patient's Name_____

Patient's Phone _____ **Preferred Language** _____

Patient's Email _____

❑ **Diabetes Prevention Program (DPP) –** 12 months, 1-hour sessions

For patients diagnosed with pre-diabetes or at-risk for diabetes.

Pre-diabetes based on the following criteria (select all that apply)

- ○ HbA1c: _____ (5.7-6.4%) Date of most recent test: _____
- ○ I am referring this person based on their BMI >25 (Asian individuals >22) BMI = _____
- ○ Gestational diabetes during previous pregnancy

❑ **Diabetes Self-Management Program** - *For patients diagnosed with diabetes.*

- ○ Diabetes Garage – for men only (4 weeks, once a week for 2-hour sessions)
- ○ Diabetes Empowerment Education Program (DEEP) **COMING IN SPRING 2023**

❑ **Health & Wellness –** 7 weeks, once a week for 1½-hour sessions

Broad overview of nutrition, physical activity, stress management, and goal setting.

- ○ Viva Health

Fax form to (210) 207-9700. Metro Health will follow up with your patient.

I consent to this referral and understand that Metro Health will contact me.

Patient Signature: _____ **Physician Signature:** _____

DiabetesHelpSA.com

For more information: Call 210-207-8802
Or Email maria.ochoa2@sanantonio.gov

DIABETES PREVENTION & CONTROL

CITY OF SAN ANTONIO TEXAS

METROPOLITAN HEALTH DISTRICT