FAX REFERRAL FORM

Physician Name: _____

Practice Name: _____

Phone #: _____

Email: _____

Diabetes Prevention and Control Programs

(Please print clearly)

Patient's Name _____

Patient's Phone _____

❑ **Pre-diabetes based on the following criteria** (select all that apply) - **Fax referral form to 210-207-4288**

- ○A1c: _____ (5.7-6.4%)
- ○Fasting Plasma Glucose: _____ (100-125 mg/dl)
- ○2-hour (75 gm glucola) Plasma Glucose: _____ (140-199mg/dl)
- ○I am referring this person based on this diagnosis and their BMI

BMI = _____ (>25, Asian individuals >22)

Metro Health will follow up with your patient.

❑ **Diabetes Self-Management Program - Fax referral form to 210-207-4288**

The Diabetes Self-Management Program is an evidence-based program developed at Stanford University. The program is open to adults with diabetes and/or their family members or caretakers and provides the tools for individuals to better control diabetes and prevent complications. The workshop is 6-weeks long and meets once a week for up to 2.5 hours.

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:** _____

CITY OF SAN ANTONIO
METROPOLITAN HEALTH DISTRICT

DiabetesHelpSA.com

For more information: Call 210-207-8802 diabeteshelpsa@sanantonio.gov