DIABETES CLINIC Patient Referral Request

Today's Date: ____________________

Patient Name: ____________________

Patient Date of Birth: ____________________

Patient Phone: ____________________

Diagnosis: ❑ Type 1 ❑ Type 2 ❑ Gestational

❑ Other ____________________

Please share any information that may be helpful in our evaluation of your patient.

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Providing specialized diabetes care with the latest treatments and technologies plus screening and diabetes education for your patients.

Your Treatment Recommendations (optional)

❑ Comprehensive program (Evaluate & Treat) — includes diabetes self-management education
❑ Continuous glucose monitoring (CGM)
❑ New insulin start
❑ Insulin pump therapy
❑ Intensive insulin therapy
❑ Screenings such as ABI & Retinal

Indicate location where an appointment should be scheduled:

❑ **Arlington/Ft. Worth**	❑ **Irving/Las Colinas**	❑ **Plano**
Renela Suller, MD **Sharain Adams, NP** 1100 Orchard Dr. Suite A Arlington, TX 76012 Phone: 817-472-8180 Fax: 210-610-3638	**Paul Lyde, MD, CDE** **Renela Suller, MD** 6420 N. MacArthur Blvd Suite 130 Irving, TX 75039 Phone: 972-402-8300 Fax: 972-373-0700	**Rosemarie Lajara, MD** **Renela Suller, MD** 3801 W. 15th Street Plano Medical Pavilion, Bldg A Suite 214 Plano, TX 75075 Phone: 469-467-0400 Fax: 210-610-3640

Referring Provider Information:

Please provide your information so we can keep you updated on your patient's progress.

Referring Physician: ____________________ Specialty: ____________________

Physician's Signature: ____________________ Phone Number: ____________________

Fax Number: ____________________

This document contains patient-sensitive information. Exercise extreme care and take all necessary steps to keep this information secure and confidential.