



Referral to Alameda County Diabetes Self-Management Education and Support Services

Referring Staff: _____ Date: _____

Referring Agency/Clinic: _____ Phone: _____ Fax _____

Eligibility

1. 18 years of age or older
2. Diagnosed with type 2 or pre-diabetes (and provide proof of diagnosis)
3. Lives in Alameda County

Through an 8 week American Diabetes Association recognized program these topics will be covered:

- Diabetes Overview
- Healthy Eating
- Taking Medications
- Reducing Risk
- Healthy Coping
- Being Active
- Monitoring Blood Sugar
- Problem Solving

Patient Name: _____ Date of Birth: _____

Street Address: _____ Apt #: _____

City: _____ Zip Code: _____ Phone Number: _____

Gender: Female Male Non-binary Gender not listed Prefer not to respond

Diagnosis: Pre-Diabetes Type 2 Diabetes

Language: English Chinese Hindi Other: _____
 Spanish Vietnamese Arabic

**Please fax completed form to the
Alameda County Diabetes Program at (510) 595-6486.**

For Office Use

1st Call (Date/Initial): _____/_____/_____	2nd Call (Date/Initial): _____/_____/_____	3rd Call (Date/Initial): _____/_____/_____
<input type="checkbox"/> No answer, letter sent: _____	<input type="checkbox"/> No answer	<input type="checkbox"/> No answer
<input type="checkbox"/> Left Message, letter sent	<input type="checkbox"/> Left Message	<input type="checkbox"/> Left Message
<input type="checkbox"/> Phone D/C; letter sent	<input type="checkbox"/> Phone D/C	<input type="checkbox"/> Phone D/C
<input type="checkbox"/> Declined Services	<input type="checkbox"/> Declined Services	<input type="checkbox"/> Declined Services
<input type="checkbox"/> Will attend class: _____	<input type="checkbox"/> Will attend class: _____	<input type="checkbox"/> Will attend class: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

Outcome Fax Sent (Date/Initial) _____