



2617 Phillips Dr. • Jonesboro, AR 72401
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Diabetes Management Program Referral Form

CLIENT INFORMATION

Name: _____ Age _____

Address: _____

Phone Number: () _____

DOB: _____

Reason for Referral: _____

Mr. / Ms. _____ is medically cleared for participation in the **diabetes management** program at the NEA Clinic Wellness Center.

Any areas of concern _____

As a part of the program, we include a Health Risk Appraisal assessment of the patient’s overall health. To make the best use of such a tool, we need the following clinical data:

- Blood Pressure _____ / _____
- Total Cholesterol _____ HDL _____ LDL _____
- Triglycerides _____
- Glucose _____
- Fasting _____
- HgbA1c _____



In addition, we will be checking the participant’s height, weight, body composition, as well as, surveying their lifestyle habits. Each participant will receive a Personal Wellness Report. A summary report of your patient’s participation and results will be sent to you if you wish. Please provide your contact information below.

Physician Name: _____

Office Address: _____

City/ST/Zip: _____

Phone: _____ Fax: _____

We look forward to working closely with your patient, to help them optimize their health and attain a greater sense of “wellness” in all aspects of their life. It takes a team effort to achieve success in changing behaviors and we welcome you and your patient to our team!