Public Health Department
Alameda County Health

REFERRAL TO ALAMEDA COUNTY
DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT SERVICES

Referring Staff: _____ Date: _____

Referring Agency/Clinic: _____ Phone: _____ Fax _____

Eligibility
18 years of age or older
Diagnosed with type 2 or pre-diabetes
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
- Problem Solving

Patient Name: _____ Date of Birth: _____

Street Address: _____ Apt #:_____

City: _____ Zip Code: _____

Phone Number: _____ ❒ Female ❒ Male

Diagnosis: ❒ Pre-Diabetes ❒ Type 2 Diabetes

Language: ❒ English ❒ Farsi ❒ Hindi
❒ Punjabi ❒ Spanish ❒ Urdu ❒ Other: _____

Please fax completed form to the
Alameda County Diabetes Program at (510) 383- 5183.

For Office Use

1st Call (Date/Initial):_____/_____ **2nd Call** (Date/Initial):_____/_____ **3rd Call** (Date/Initial):_____/_____

☐ No answer, letter sent: _____	☐ No answer	☐ No answer
☐ Left Message, letter sent	☐ Left Message	☐ Left Message
☐ Phone D/C; letter sent	☐ Phone D/C	☐ Phone D/C
☐ Declined Services	☐ Declined Services	☐ Declined Services
☐ Will attend class: _____	☐ Will attend class: _____	☐ Will attend class: _____
☐ Other:_____	☐ Other:_____	☐ Other:_____

□ **Outcome Fax Sent (Date/Initial)** _____