# Diabetes Follow Up

Patient Label

Referring Physician: _____

Date: _____

| **Assessment** (Diet, Activity, Current Medications, Other) | **Items for Discussion** (eg. Driving guidelines, sick day management etc) |
|---|---|
| ☐ Clinic Visit ☐ Phone/Email<br>☐ Supporting documents attached | |
| | **Additional Notes** |
| | |
| | **Recommendations** |
| | |

**Next Follow-Up**

| | | | |
|---|---|---|---|
| **Clinic:** | ☐____ Weeks | ☐ ____ Months | ☐ NONE |
| **Phone/Email:** | ☐ ____ Days | ☐____ Weeks | ☐ PRN |

Educator: _____ Date: _____