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 ☐ Supporting documents attached	
	Additional Notes
	Recommendations

Next Follow-Up

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

Educator: _____ Date: _____