

Rutland Region Diabetes & Endocrinology Center Referral Form

Service Requested: Endocrine Consult Only Diabetes Education Only Both Other

Patient Name: _____

Date: _____ DOB: _____ Phone: _____

Address: _____

Insurance: _____ Referral Needed? Yes No

Reason for referral – diagnosis: _____

Referring MD Name: _____ Phone _____

Referring MD Signature _____

Before we can schedule the patient we need the following information:

For **ALL** patients:

- Problem List
- Medication List
- Pertinent Lab/X-ray Reports

For **Diabetes** patients, please also include:

- Dates of last influenza _____ and pneumococcal vaccines _____
- Copy of latest eye doctor report
- All labs done in past 12 months

for RRDEC office use only

- 20 min Routine MD only
- 40 min ASAP Next available provider
- 60 min
- Have patient bring films _____ Have DI send films _____

Appt. date and time: _____ Mailed info to pt. date: _____

Fax 802.775.9017