

# Humboldt IPA Diabetes Podiatry Exam Referral and Report

## REFERRAL INFORMATION

Referred By: _____	Fax #: _____
Referred To: _____	Fax #: _____
Reason for Referral: _____	
_____	
Patient's Name: _____	Date of Birth: _____ Gender: M F
Home Phone: _____	Insurance: _____
Address: _____	
_____	

**REPORT** (fax to Referring Clinician at above fax number and to Humboldt IPA for PECSYS registry at 443-2527)

<b>Diagnosis:</b>
<input type="checkbox"/> Neuropathy <input type="checkbox"/> Onychomycosis <input type="checkbox"/> Peripheral Vascular Disease (PVD)
<input type="checkbox"/> Ulceration <input type="checkbox"/> Other _____
<b>Treatment Recommended:</b> _____
_____
_____
_____
<b>Treatment Provided:</b> _____
_____
_____
_____

**Alert Risk:**  Minimal  Moderate  High

**Follow-up Recommended Return:** \_\_\_ Days \_\_\_ Month(s) \_\_\_ Year(s)

**Clinician's Name** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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