

# Physician Diabetes Consultation Form



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Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

**\*Please complete all parts of the following form, sign, and fax back to 757-683-3970\***

Date of last A1c test \_\_\_\_\_ A1c Result \_\_\_\_\_

Patient interval of A1c testing required by physician (please check)  
Every 3 months    Ever    Ever  
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