



625 West Citracado Parkway, Suite 112
 Escondido, CA 92025
 Phone: 760 466-1520
 Fax: 760 466-1525

RESEARCH REFERRAL FORM

Referring Provider Name/ Clinic: _____ Referral Date: _____

Address: _____ City: _____

ZIP: _____ Phone: _____ Fax: _____

Patient provided verbal consent to provide their information

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Cell Phone/Other: _____

Best time to reach: _____ AM _____ PM

May we leave a message at these numbers? Yes No

Diabetes Type: 1 2 Year of Diagnosis: _____

Most recent A1c: _____% Date of A1c: _____

Current diabetes medications: Orals Insulin Both

I agree to share my information with AMCR Institute, Inc.

Signed: _____ Date: _____

Please fax completed form to (760) 466-1525 with a copy of the patient's medical history, physical and medication list. AMCR Institute will call and screen the patient within three business days and return the screen results to you.

FOR AMCR INSTITUTE USE ONLY:
Patient: <input type="checkbox"/> is eligible Name of Study: _____ Screen Date: _____
Patient: <input type="checkbox"/> is not eligible due to the following reasons: <input type="checkbox"/> A1c <input type="checkbox"/> Age <input type="checkbox"/> Type of Diabetes <input type="checkbox"/> BMI <input type="checkbox"/> Medication regimen <input type="checkbox"/> Other: _____