



Institutional logo

DREAM Atlanta Physician Referrals
Ver. 04.16.2020

Thank you for referring one of your patients to our study.
Please fill out the following information for patients who meet the key eligibility criteria, summarized here, for your reference:

- a) South Asian ethnicity; and
- b) Between 21 - 75 years of age; and
- c) Diagnosis of diabetes in the EHR, OR A1c value of $\geq 6.5\%$ in last year; AND
- d) Uncontrolled BP reading ($>130/80\text{mmHg}$) documented in office visit in the last 6 months

Referred by [physician's name]: _____

Date: ____ / ____ / ____

Patient's name: _____

Patient's DOB: ____ / ____ / ____

Ethnicity: ☐ Bangladeshi ☐ Indian ☐ Pakistani ☐ Other: _____

Diagnosis of hypertension? ☐ Yes ☐ No ☐ Unknown

Blood pressure reading: ____ / ____ Date: _____

Diagnosis of diabetes? ☐ Yes ☐ No ☐ Unknown

HbA1c: _____ Date: _____

Patient's phone number: _____

Language(s) Spoken

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Hindi |
| <input type="checkbox"/> Bangla/Bengali | <input type="checkbox"/> Nepali |
| <input type="checkbox"/> Urdu | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Punjabi | |