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Indigenous Diabetes Health Circle
Foot Care Program – Client Clinic Transfer Form

Name:_____Phone # _____

Current Address:_____

_____

Current Foot Clinic location and Service Provider Name

_____

_____

Last foot care appointment: Date and time

_____

Transfer to which Foot Care Clinic

Service Provider Name:_____

Service Provider Location:_____

Describe reason to change foot clinic:

_____

_____

Client signature

_____

Host/Service Provider Signature

_____