Therapie Aktiv
DIABETES IM GRIFF

PARTICIPATION and CONSENT FORM
Disease Management Program Diabetes mellitus Typ 2

_____
Surname, first name of insured party/patient

☐☐☐☐☐☐☐☐☐☐

Health insurance number

_____
Healthcare fund

_____
Address (street/post code/ city)

- I herewith declare myself willing to actively take part in the „Active Therapy“ program. I will agree therapy goals with my physician (more exercise, healthy eating, stop smoking, improved blood pressure and lab results, weight reduction) and will do my best to achieve these goals.
- I agree to receive messages relating to diabetes from my social insurance as part of the program.
- I can withdraw this consent at any time in writing and by submitting a written withdrawal will automatically be withdrawn from the Disease Management Program Diabetes mellitus Type 2.

_____
Date Patient’s signature

To be filled out by physician:

☐ First registration ☐ Change of physician

_____
Place, date of registration

_____
Signature of „Therapie Aktiv“–physician

_____
Name, contract partner number

_____
Address

_____
Surgery stamp

DVR-Nr. 0024015