

Referral to the Diabetes Education Program

3305 Harvester Road, Units 15-20, Burlington, Ontario, L7N 3N2
Fax #: 905-681-6341 Phone #: 905-632-8007 ext 107



****Please refer patients who have Type 1 Diabetes, Gestational Diabetes, Pediatrics and those requiring pump therapy to an Endocrinologist****

Patient Name: _____ Health Card Number: _____
DOB (month/date/year): _____ Sex: Male Female
Home Address: _____ City: _____ Postal Code: _____
Primary Contact Number: _____ Alternate Contact Number/Email Address: _____

<u>Type of Diabetes</u> <input type="checkbox"/> Newly Diagnosed Type 2 <input type="checkbox"/> Pre-existing Type 2 Diabetes (for __ years) <input type="checkbox"/> Pre-Diabetes
--

<u>Reason for Referral</u> <input type="checkbox"/> URGENT 24-48 hours <input type="checkbox"/> Diabetes Education <input type="checkbox"/> Individual OR <input type="checkbox"/> Group <input type="checkbox"/> Diet Education Only <input type="checkbox"/> Meter Teaching <input type="checkbox"/> <u>Insulin Start</u> Dr. Signature: _____ (for insulin start/adjustment only) <input type="checkbox"/> Insulin Type: _____ <input type="checkbox"/> Insulin Dose and Time: _____ <input type="checkbox"/> Certified Diabetes Educator (RN or RD) will teach patient insulin dose titration to their individual specific target

Medications:

<u>Current Diabetes Medications</u>	<u>Other Medications</u>

Copy of most recent Lab Report Included **(Please include most recent A1C and FBS (2 values) and most recent Lipids, Cr, ACR)**

Medical History:

- Cardiovascular Disease Renal Disease Foot/Wound Concerns
- Dyslipidemia Retinopathy Other: _____
- Hypertension Neuropathy

Factors which may affect learning: i.e. language barrier, literacy concerns, visual impairment, mental health issues, financial concerns:
Please list: _____

Referring Doctor Name: _____	Referring Doctor Signature: _____
Date of Referral: _____	Referring Doctor Fax #: _____