Stand up to Diabetes
Faisons face au diabète

**REFERRAL FORM**
**Central Intake Fax: 1-855-DIABETS (342-2387)**
**Central Intake Phone: 1-844-204-9088**

**Last Name:** **First Name:** **Gender:** **DOB (dd/mm/yy):**
**Address:** **City:** **Postal Code:**
**Telephone:** D: E: **Language Barrier:** ☐YES ☐NO
**Primary Care Provider Name / Phone Number:** **Language Spoken:** _____
**Health Card Number:** ☐**Southwest Ontario Aboriginal Health Access Centre Service Preferred**

**DIABETES ASSESSMENT (please check all that apply)**

☐ URGENT
☐ Symptomatic
☐ New Diagnosis (<1 yr)
☐ Established (>1yr)

☐ Type 1
☐ Type 2
☐ Pre-diabetes
☐ Steroid induced

☐ High Risk for DM
☐ _____
☐ No Previous Education

If **PREGNANT** check below:

| | | |
|---|---|---|
| ☐ Type 1 | ☐ Repeat GDM | Due Date: |
| ☐ Type 2 | ☐ High Risk | Hospital: |
| ☐ GDM | ☐ Postpartum | |

**REASON FOR REFERRAL (please check all that apply)**

☐ Diabetes Education
☐ Poor Diabetes Control
☐ Hypoglycemia
☐ Pre-Pregnancy Counselling
☐ Other (please specify)_____

☐ Weight Control
☐ Carb Counting
☐ Lipid Management
☐ Sick Day Management

☐ Insulin Start – See Order Below
☐ Insulin Pump
☐ CGMS
☐ GLP-1 Start: _____

☐ Insulin Adjustment Education
☒ Foot Care Education
☐ Foot Care Treatment

**ORDERS FOR INSULIN INITIATION AND/OR ONGOING ADJUSTMENTS**

| | | |
|---|---|---|
| Insulin Type: | | ☐ Adjust insulin dose by 1-2 units or up to 20% prn to achieve CDA CPG glycemic targets of ac 4-7 mmol/L and pc 5-10mmol/L or individual target of:_____ |
| Dose and Time: | | |
| Insulin Type: | | ☐ Adjust insulin dose by 1-2 units or up to 20% prn to achieve CDA CPG glycemic targets of ac 4-7 mmol/L and pc 5-10mmol/L or individual target of: _____ |
| Dose and Time: | | |

☐ Allow Certified Diabetes Educator to reduce the secretagogue dosage accordingly to avoid hypoglycemia
☐ Allow Certified Diabetes Educator to adjust carb/insulin ratios for self management of insulin therapy
☐ Allow Certified Diabetes Educator to order blood glucose or A1c for assessment and evaluation of glycemic control
☐ Allow Registered Dietitian to perform blood glucose monitoring with a meter

**CURRENT THERAPY AND MEDICAL HISTORY**

**Check all that apply and include types and dosages**
☐ **Insulin** ☐ **Antihyperglycemic Agents**

☐ **History attached**
☐ Hypertension (>130/80)
☐ CVD
☐ PAD
☐ TIA/Stroke
☐ Retinopathy

☐ Nephropathy
☐ Exercise restrictions
☐ Neuropathy
☐ Vegetarian
☐ Psychosocial
_____

☐ Dyslipidemia
☐ Alcohol Use
☐ Sex Dysfunction
☐ Tobacco Use
☐ Foot ulcers
☐ Other
_____

****LAB RESULTS (Please Record or Fax Copy)****

| Test | Result | Date | Test | Result | Date |
|---|---|---|---|---|---|
| FBS | | | Creatinine | | |
| 2hr OGTT | | | T Chol/HDL Ratio | | |
| A1C | | | Triglycerides | | |
| ACR | | | HDL Cholesterol | | |
| eGFR | | | LDL Cholesterol | | |

☐ Endocrinologist/Specialist in Diabetes Consult _____
☐ Ophthalmologist Retinal Screening/Consult _____
**If requesting consult, provide your billing number* _____

Signature: _____ Date: _____

Print Name: Phone: Fax:

Address (stamp):

**For Internal Use ONLY**
**DEP:**
**Specialist:**

**For DEP Use ONLY**
**First Contact:**
**Appointment Dates:**

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