Central East Centralized Diabetes Intake Referral Form

For Access to Diabetes Education Programs and the Centre for Complex Diabetes Care

Phone: 1-888-997-9996 Fax: 1-905-444-2544 Toll Free Fax: 1-844-731-2161

Referral forms can be found at: **http://healthcareathome.ca/centraleast/en**

Patient Information

Name: _____ Gender: _____ DOB (dd/mm/yy): _____

Address: _____ City: _____ Postal Code: _____

Date patient informed of referral: _____ Health Card Number: _____

Daytime Phone: _____ Alternate Phone: _____

Primary language spoken: _____ Translation required: ☐ Yes ☐ No

Primary Care Provider: _____ Primary Care Provider contact: _____

Diabetes Specialist: _____ Diabetes Specialist contact: _____

Diabetes-Related Health Information and Reason for Referral

(To enable us to determine the appropriate program, as well as urgency for assessment, please fill out as completely as possible)

Type of diabetes: *Type 1* ☐ new ☐ established *Type 2* ☐ new ☐ established ☐ Pre-diabetes If pregnant: ☐ Type 1 ☐ Type 2 ☐ GDM

Due Date (dd/mm/yy): _____

Comorbidities:
- ☐ later stages of kidney disease or renal failure
- ☐ neurological conditions such as stroke, progressive neuropathy
- ☐ recurrent cardiac conditions such as congestive heart failure, myocardial infarct, angina
- ☐ retinopathy or vision threatened
- ☐ mental health/cognitive concerns
- ☐ uncontrolled hypertension
- ☐ obesity

Other Issues:
- ☐ recent repeated hospital admissions that may benefit from specialized out-patient follow-up
- ☐ recent repeated emergency room visits that may benefit from specialized out-patient follow-up
- ☐ other barriers (e.g.: financial, frail elderly, mobility, etc.): _____

Reason for referral: _____

- ☐ BG 15-20 mmol/L
- ☐ BG >20 mmol/L
- ☐ A crisis that drastically affects the individual's ability to manage their diabetes
- ☐ Recent treatment for DKA / HHS
- ☐ Severe hypoglycemia
- ☐ A1C 8.5 – 10%
- ☐ A1C > 10%
- ☐ Education
- ☐ Insulin initiation / GLP1 initiation
- ☐ Change in Insulin regimen
- ☐ Recent discharge from hospital/ER related to diabetes
- ☐ Pre-pregnancy counselling
- ☐ Insulin Pump therapy
- ☐ Inpatient, admitted related to diabetes

Expected date of discharge: _____

Where applicable, do you agree to refer your patient to a specialist? ☐ Yes ☐ No

Medication: Please attach current medications or list here:

Relevant Medical History

Laboratory Tests:
Most recent blood work, including A1C completed within the last 3 months **must be attached**. Creatinine, lipid profile, ACR and any other additional blood work would also be helpful.

Relevant Diagnostic Tests:
Please attach relevant test reports.

Referred by: _____ Contact phone: _____ Fax: _____

Signature: _____ Referral date (dd/mm/yy): _____

Ontario
Central East Local Health Integration Network