DIABETES EDUCATION PROGRAM (DEP) REFERRAL FORM

CLIENT NAME: _____ M ☐ F ☐ DOB(DD/MM/YY): _____ AGE: _____

PARENT/GUARDIAN'S NAME(IF LESS THAN 18 YEARS OF AGE) _____ HEALTH CARD #: _____

ADDRESS: _____

PHONE(HOME): _____ PHONE(WORK): _____ PHONE(CELL): _____

☐ Self−Referral: If so, do you have: Type 1 ☐ or Type 2 ☐ Diabetes

FOR TYPE 1 DIABETES:

☐ **CHARLES H. BEST CENTRE**
FAX 905−620−0579

☐ **MARKHAM−STOUVILLE HOSPITAL**
☐ UXBRIDGE
FAX 905−852−2460

FOR TYPE 2 DIABETES:

☐ **LAKERIDGE HEALTH**
☐ AJAX−PICKERING
FAX 905−428−5248
☐ BOWMANVILLE
☐ PORT PERRY
☐ WHITBY
FAX 905−665−2404

☐ **CAREA COMMUNITY HEALTH CENTRE**
☐ AJAX
☐ PICKERING
☐ OSHAWA
FAX 905−723−3391

☐ **BROCK COMMUNITY HEALTH CENTRE**
☐ CANNINGTON
☐ BEAVERTON
☐ SUNDERLAND
FAX 705−426−3330

☐ **MARKHAM−STOUVILLE HOSPITAL**
☐ UXBRIDGE
FAX 905−852−2460

Please complete and fax prior to client attending the Diabetes Education Program.
The DEP will contact the client to book an appointment.

Is client currently followed by Diabetes Specialist (Endocrinologist/Internist)? ☐ Yes If yes, who? _____ ☐ No

Consult with Diabetes Specialist (Endocrinologist/Internist) requested: ☐ Yes ☐ No

TYPE OF DIABETES:

Type 1 ☐ New ☐ Established

Type 2 ☐ New ☐ Established

☐ Prediabetes

If pregnant check below:

☐ Type 1
☐ Type 2
☐ GDM

EDC _____

MEDICAL HISTORY − Check ALL that apply OR ☐ HISTORY ATTACHED

☐ Thyroid disease
☐ Hypertension (>130/80)
☐ Dyslipidemia
☐ Cardiovascular disease
☐ Tobacco use
☐ Alcohol abuse
☐ Sexual dysfunction
☐ Retinopathy
☐ Nephropathy − Followed by: _____
☐ Foot Problems/Wound Concerns
☐ Neuropathy
☐ Exercise restrictions/Mobility issues
_____
☐ Mental Health Concerns
_____
Other: _____

MEDICAL/NUTRITION THERAPY:

☐ Yes, appropriate for group
☐ No, not appropriate for group.
If not, explain why _____

☐ Nutrition recommendations will be at Dietitian's discretion
☐ Additional nutrition considerations:
_____
_____

LABORATORY DATA:

☐ REPORTS **MUST** BE ATTACHED AND SHOULD INCLUDE THE FOLLOWING RESULTS:

- FPG
- 75g OGTT − FPG− 2−hour
- A1c
- TC
- HDL−C
- LDL−C
- TC
- HDL
- TG
- ACR
- Serum Creatinine
- eGFR
- TSH

☐ FOR GESTATIONAL DIABETES:
- 50g OGTT − FPG − 1 hour & 2 hour
- A1c

PRESENT TREATMENT FOR DIABETES:

☐ Healthy Lifestyle
☐ Oral Agents: Type & Dose
_____
_____

☐ Insulin pump
☐ Victoza ®
☐ Byetta ®
☐ Insulin:

	Dosage			
Type:	am	noon	pm	HS

☐ **INSULIN INITIATION/CHANGE ORDERS**

	Dosage			
Type:	am	noon	pm	HS

COMMENTS:

Referring Physician: _____

PRINT NAME **SIGNATURE** **PHONE NUMBER** **DATE**

FOR OFFICE USE

Priority: **1** **2** **3** **4** **Date Received by:** _____

REF0035