WaterlooWellington DIABETES.ca

REFERRAL FORM
Central Intake Fax: 1-855-DIABETS (342-2387) or 519-650-3114
Central Intake Phone: 519-653-1470 x372

Patient Name: ☐ **M** ☐ **F** **DOB (dd/mm/yy):**
Address: **City:** **Postal Code:**
Telephone: D: E: **Language Barrier:** ☐ YES ☐NO
Health Card Number: **Language Spoken:** ____________________
Primary Care Provider Name and Phone Number:

DIABETES ASSESSMENT (please check all that apply)

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

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

☐ Other ___________
☐ No Previous Education

If **PREGNANT** check below:

☐ Type 1	☐ GDM	Due Date:
☐ Type 2	☐ Repeat GDM	Hospital:
	☐ Postpartum	

REASON FOR REFERRAL (please check all that apply)

☐ Diabetes Education
☐ Poor Diabetes Control
☐ Self-Management of Insulin Adjustments
☐ Weight Control
☐ Carb Counting
☐ Foot Care Education
☐ Insulin Pump
☐ Insulin Start – See Order Below
☐ Hypoglycemia
☐ Lipid Management
☐ Pre-Pregnancy Counselling
☐ Other (please specify)____
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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**

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

☐ Nephropathy
☐ Exercise restrictions
☐ Neuropathy
☐ Vegetarian
☐ Psychosocial
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☐ 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 __________________________
☐ Nephrologist/HTN Clinic 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: