WaterlooWellington DIABETES.ca

REFERRAL FORM
Central Intake Fax: 1-855-DIABETS (342-2387) or 519-650-3114
Central Intake Phone: 1-844-204-9088 or 519-947-1000

Last Name: **First Name:** ☐ **M** ☐ **F** **DOB (dd/mm/yy):**

Address: **City:** **Postal Code:**

Telephone: D: E: **Language Barrier:** ☐ YES ☐ NO

Health Card Number: ☐ Aboriginal Status **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

☐ 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 _____
☐ 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: