

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 Type 1 High Risk for DM **If PREGNANT check below:**
 Symptomatic Type 2 _____ Type 1 Repeat GDM **Due Date:** _____
 New Diagnosis (<1 yr) Pre-diabetes No Previous Type 2 High Risk **Hospital:** _____
 Established (>1yr) Steroid induced Education GDM Postpartum

REASON FOR REFERRAL (please check all that apply)

Diabetes Education Weight Control Insulin Start – See Order Below Insulin Adjustment Education
 Poor Diabetes Control Carb Counting Insulin Pump Foot Care Education
 Hypoglycemia Lipid Management CGMS Foot Care Treatment
 Pre-Pregnancy Counselling Sick Day Management GLP-1 Start: _____
 Other (please specify) _____

ORDERS FOR INSULIN INITIATION AND/OR ONGOING ADJUSTMENTS

Insulin Type:		<input type="checkbox"/> 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:		<input type="checkbox"/> 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 Nephropathy Dyslipidemia
 Hypertension Exercise restrictions Alcohol Use
 (>130/80) Neuropathy Sex Dysfunction
 CVD Vegetarian Tobacco Use
 PAD Psychosocial Foot ulcers
 TIA/Stroke Retinopathy _____ 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: _____