

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 2 DIABETES:

- LAKERIDGE HEALTH
 AJAX-PICKERING
 BOWMANVILLE
 PORT PERRY
 WHITBY
 FAX 905-665-2404

- CAREA COMMUNITY HEALTH CENTRE
 OSHAWA
 AJAX
 FAX 905-723-3391

- BROCK COMMUNITY HEALTH CENTRE
 CANNINGTON
 BEAVERTON
 SUNDERLAND
 FAX 705-426-3330

FOR TYPE 1 DIABETES:

- CHARLES H. BEST CENTRE
 FAX 905-620-0579

**Please complete and fax prior to client attending the Diabetes 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

- | | |
|---|--|
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Nephropathy - Followed by: _____ |
| <input type="checkbox"/> Hypertension (>130/80) | <input type="checkbox"/> Foot Problems/Wound Concerns |
| <input type="checkbox"/> Dyslipidemia | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Exercise restrictions/Mobility Issues |
| <input type="checkbox"/> Tobacco Use | _____ |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Mental Health Concerns |
| <input type="checkbox"/> Sexual Dysfunction | _____ |
| <input type="checkbox"/> Retinopathy | Other: _____ |

MEDICAL/NUTRITION THERAPY

- Yes appropriate for group.
 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 | • TC |
| • 75g OGTT- FPG- 2-hour | • HDL |
| • A1c | • TG |
| • TC | • ACR |
| • HDL-C | • Serum Creat |
| • LDL-C | • 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:

Type:	Dosage			
	am	noon	pm	HS

INSULIN INITIATION/CHANGE ORDERS

Type:	Dosage			
	am	noon	pm	HS

COMMENTS:

Referring Physician:

PRINT NAME

SIGNATURE

PHONE NUMBER

DATE

FOR DEP OFFICE USE

Priority: 1 2 3 4

Date Received by DEP: _____