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

☐ 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.
☐ 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 Creat
- 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 DEP OFFICE USE

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

REVISED: AUGUST, 2017