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 1 DIABETES:

☐ **CHARLES H. BEST CENTRE** FAX 905-620-0579	☐ **MARKHAM-STOUVILLE HOSPITAL** ☐ UXBRIDGE FAX 905-852-2460

FOR TYPE 2 DIABETES:

☐ **LAKERIDGE HEALTH** ☐ AJAX-PICKERING FAX 905-428-5248 ☐ BOWMANVILLE ☐ PORT PERRY ☐ WHITBY FAX 905-665-2404	☐ **CAREA COMMUNITY HEALTH CENTRE** ☐ AJAX ☐ PICKERING ☐ OSHAWA FAX 905-723-3391	☐ **BROCK COMMUNITY HEALTH CENTRE** ☐ CANNINGTON ☐ BEAVERTON ☐ SUNDERLAND FAX 705-426-3330	☐ **MARKHAM-STOUVILLE HOSPITAL** ☐ UXBRIDGE FAX 905-852-2460

Please complete and fax prior to client attending the Diabetes Education 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.
☐ No, 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 Creatinine
- 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 OFFICE USE

Priority: **1** **2** **3** **4** **Date Received by:** ______________

REVISED: MAY 2019