Carea Community Health Centre

Personal/Contact Information

Name: ____

Address: ____

City: __________________ Postal Code: _________________

Phone: (___) ____ - _______ Cell: (___) ____ - _______

Health Card: _____________________________

VC ___________ **Expiry Date:** ____ _______

DOB: ______/______/ ________

Preferred method of contact: ____________________________

Can we leave messages? Y ____ N_____ Email address: _____________________________________

Emergency Contact: ______________________________Phone Number: (____) ____ - _______ Relation: _________

Family Doctor/NP: ________________________________Tel: (____) ____ - _____ Fax: (____) ____ - _____

Diabetes Information

Type of Diabetes: ☐ Type 2 diabetes ☐ Prediabetes ☐ Unknown

Have you received diabetes education before? ☐ No ☐ Yes Where/When?______________________________

What types of services are you looking for (Check all that apply):

☐ Diet management ☐ Diabetes medication education ☐ Glucose monitoring ☐ Foot Care

☐ Insulin start or titration

Details: ____

Medical History

☐ Heart disease ☐ Retinopathy ☐ High Blood Pressure ☐ Mental Health Concerns

☐ Chronic Kidney Disease ☐ Tobacco Use ☐ Other____

Are you currently taking any medication for your diabetes? If yes please list:

____

The Diabetes Education Program, includes one initial assessment and 2-3 follow up appointments. In order to provide the best care necessary for you, we may need to access your medical records. Do you give consent for the health care team to access your medical records?

_____________________________ _____________________________

Signature **Date**