

# DURHAM REGION DIABETES PROGRAM REFERRAL FORM

Client Name: \_\_\_\_\_ M  F  DOB (dd/mm/yy): \_\_\_\_\_ Age: \_\_\_\_\_  
 Parent/Guardian (if less than 18 years of age): \_\_\_\_\_ Health Card #: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_ Phone (Work): \_\_\_\_\_ Phone (Cell): \_\_\_\_\_

**CLIENT'S PREFERRED LOCATION TO ATTEND:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> LAKERIDGE HEALTH – PORT PERRY<br>FAX 906-665-2404       | <input type="checkbox"/> LAKERIDGE HEALTH – WHITBY<br>FAX 905-665-2404            | <input type="checkbox"/> LAKERIDGE HEALTH – COURTICE HEALTH CENTRE<br>FAX 905-665-2404 |
| <input type="checkbox"/> MARKHAM STOUFFVILLE – UXBRIDGE SITE<br>FAX 905-852-2460 | <input type="checkbox"/> ROUGE VALLEY – AJAX/PICKERING SITE<br>FAX 905-428-5248   | <input type="checkbox"/> ROUGE VALLEY – CENTENARY SITE<br>FAX 416-281-7020             |
| <input type="checkbox"/> OSHAWA COMMUNITY HEALTH CENTRE<br>FAX 905-723-3391      | <input type="checkbox"/> CHARLES H. BEST CENTRE (TYPE 1 ONLY)<br>FAX 905-620-0579 | <input type="checkbox"/> BROCK COMMUNITY HEALTH CENTRE<br>FAX 705-432-3039             |

***This form must be completed and faxed by Referring Physician prior to client attending the Diabetes Program.  
The DEC will contact patient.***

Is Client currently followed by Diabetes Specialist (Endocrinologist/Internist)?  Yes If yes, who? \_\_\_\_\_  No  
 Consult with Diabetes Specialist (Endocrinologist/Internist) requested:  Yes  No  
 Please note Diabetes Specialist (Endocrinologist/Internist) services **only** available at: LAKERIDGE HEALTH ROUGE VALLEY CHARLES H. BEST CENTRE (TYPE 1 ONLY)

<b>TYPE OF DIABETES:</b> Type 1 <input type="checkbox"/> New <input type="checkbox"/> Established Type 2 <input type="checkbox"/> New <input type="checkbox"/> Established <input type="checkbox"/> Prediabetes	If <b>pregnant</b> check below: <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> GDM <input type="checkbox"/> IGT of Pregnancy <input type="checkbox"/> Prediabetes  EDC _____	<b>MEDICAL HISTORY: CHECK ALL THAT APPLY</b> <input type="checkbox"/> <b>History attached</b> <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Hypertension (>130/80) <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Cardiovascular disease <input type="checkbox"/> Tobacco Use <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Sexual Dysfunction <input type="checkbox"/> Retinopathy	<b>MEDICAL HISTORY (CONT):</b> <input type="checkbox"/> Nephropathy - Followed by: _____ <input type="checkbox"/> Foot Problems/Wound Concerns <input type="checkbox"/> Neuropathy <input type="checkbox"/> Exercise restrictions/Mobility Issues  <input type="checkbox"/> Mental Health Concerns  <input type="checkbox"/> 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:  
 \_\_\_\_\_

**PRESENT TREATMENT FOR DIABETES**

Healthy Lifestyle  
 Oral Agents: Type & Dose \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Insulin pump  
 Victoza  
 Byetta  
 Insulin:

Type:	Dosage			
	am	noon	pm	HS

**REQUIRED LABORATORY DATA:**  See attached copies.

Date: \_\_\_\_\_ FPG: \_\_\_\_\_ casual: \_\_\_\_\_  
 Date: \_\_\_\_\_ 75g OGTT FPG: \_\_\_\_\_ 2-hour: \_\_\_\_\_  
 A1c: \_\_\_\_\_ Date: \_\_\_\_\_  
 TC: \_\_\_\_\_ HDL-C: \_\_\_\_\_ LDL-C: \_\_\_\_\_ TC:HDL \_\_\_\_\_  
 TG: \_\_\_\_\_ ACR: \_\_\_\_\_ Serum Creat: \_\_\_\_\_  
 eGFR: \_\_\_\_\_ TSH: \_\_\_\_\_  
 Other: \_\_\_\_\_

**GESTATIONAL ONLY**

50g Oral Glucose Screen: Date: \_\_\_\_\_ 1 hour: \_\_\_\_\_  
 OGTT  
 Date: \_\_\_\_\_ FPG: \_\_\_\_\_ 1-hr: \_\_\_\_\_ 2-hr: \_\_\_\_\_  
 A1c: \_\_\_\_\_

**INSULIN INITIATION/CHANGE ORDERS**

Type:	Dosage			
	am	noon	pm	HS

**COMMENTS**

Physician/NP's signature authorizes Diabetes Educator to adjust existing diabetes treatment plan according to Medical Directive of institutional policy.

Referring physician: \_\_\_\_\_  
print name
signature
phone
date

**For DEC office use:**  
 Priority: 1    2    3    4                      Date Received: \_\_\_\_\_