HURON PERTH **diabetes**
Education | Support | Management

Huron Perth Diabetes Program Referral
Huron Perth Healthcare Alliance

Stratford General Hospital   Seaforth Community Hospital   St. Marys Memorial Hospital
Phone: 519 272-8210 ext. 2365
Fax: 519 272-8188

NAME	**Referral Date**
ADDRESS	**Date of Diagnosis**
Phone # (h) ___________ (cell) ____________ (w)____________	**DOB** Day/month/year
Phone Number can be reached at during day: ________________	**OHIP Number**

REASON FOR REFERRAL – comments/special instructions

Diagnosis: ☐ **New** ☐ **Type 1** ☐ **Type 2** ☐ **IGT/IFG** ☐ **Gestational**

Currently does self-glucose monitoring ☐ **Yes** ☐ **No**

ATTACH RECENT BLOOD WORK – within past 3 months (i.e. HbA1C, Lipids, Glucose, etc.)

*****Referrals will not be accepted without supporting lab documents*. ****

MEDICATIONS: *If referred for insulin start please clearly indicate prescribed initial insulin regimen and have patient fill prescription at the drug store and bring along to insulin start session.*

Other medications/conditions affecting diabetes:

Authorization for DEC Medical Directives

☐ Insulin Dose adjustments may be titrated by the Certified Diabetes Educator (CDE) according to current Medical Directive(s).

OTHER RELEVANT HEALTH PROBLEMS

		☐ Coronary	☐ Dyslipidemia	☐ Exercise Restrictions
☐ High Risk Feet	☐ Hypertension	☐ Nephropathy	☐ Neuropathy	☐ Overweight
☐ Psychosocial	☐ Retinopathy	☐ Smoker	☐ Other__________________	

Family Physician:	**Office Use:** **Stamp Date received at DEC**	**Office use only:** **Recent A1C:______%** **Triage:** / **Site:** □ **Urgent** □ **Team** □ **Stratford** □ **1-2 weeks** □ **RN only** □ **Seaforth** □ **2-3 weeks** □ **RD only** □ **St. Marys** □ **3-4 weeks** Previous patient: Yes □ No □ Last seen at DEC: ______________________
Referring Health Care Professional:		

Office use:
Date contacted: **Appointment Date & Time: _______________**