

<b>NAME</b>		<b>Referral Date</b>
<b>ADDRESS</b>		<b>Date of Diagnosis</b>
Phone # (h) _____ (cell) _____ (w) _____		<b>DOB</b> Day/month/year
Phone Number can be reached at during day: _____		<b>OHIP Number</b>
<b>REASON FOR REFERRAL – comments/special instructions</b>		
<b>Diagnosis:</b> <input type="checkbox"/> New <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> IGT/IFG <input type="checkbox"/> Gestational		
<b>Currently does self-glucose monitoring</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>ATTACH RECENT BLOOD WORK</b> – within past 3 months (i.e. HbA1C, Lipids, Glucose, etc.)  <p style="text-align: center;">****Referrals will not be accepted without supporting lab documents. ****</p>		
<b>MEDICATIONS:</b> <i>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.</i>		
<i>Other medications/conditions affecting diabetes:</i>		
<b>Authorization for DEC Medical Directives</b> <input type="checkbox"/> Insulin Dose adjustments may be titrated by the Certified Diabetes Educator (CDE) according to current Medical Directive(s).		
<b>OTHER RELEVANT HEALTH PROBLEMS</b> <input type="checkbox"/> Coronary <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Exercise Restrictions <input type="checkbox"/> High Risk Feet <input type="checkbox"/> Hypertension <input type="checkbox"/> Nephropathy <input type="checkbox"/> Neuropathy <input type="checkbox"/> Overweight <input type="checkbox"/> Psychosocial <input type="checkbox"/> Retinopathy <input type="checkbox"/> Smoker <input type="checkbox"/> Other _____		
<b>Family Physician:</b>  <b>Referring Health Care Professional:</b>	<b>Office Use:</b> <b>Stamp Date received at DEC</b>	<b>Office use only:</b> <b>Triage:</b> <b>Recent A1C:</b> _____ % <input type="checkbox"/> <b>Urgent</b> <input type="checkbox"/> <b>Team</b> <input type="checkbox"/> <b>1-2 weeks</b> <input type="checkbox"/> <b>RN only</b> <input type="checkbox"/> <b>2-3 weeks</b> <input type="checkbox"/> <b>RD only</b> <input type="checkbox"/> <b>3-4 weeks</b> Previous patient: Yes <input type="checkbox"/> No <input type="checkbox"/> Last seen at DEC: _____
<b>Office use:</b> <b>Date contacted:</b>		<b>Appointment Date &amp; Time:</b> _____