



**Huron Perth Diabetes Program Referral
Listowel Wingham and Area Family Health Team
North Huron (Wingham) Location**

Phone: 519 357-3930

Fax: 519 357-3928

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: <input type="checkbox"/> New <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> IGT/IFG <input type="checkbox"/> Gestational		
Currently does self-glucose monitoring <input type="checkbox"/> Yes <input type="checkbox"/> No		
ATTACH RECENT BLOOD WORK – within past 3 months (i.e. HbA1C, Lipids, Glucose, etc.) <p align="center">****Referrals will not be accepted without supporting lab documents. ****</p>		
MEDICATIONS: <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>		
Other medications/conditions affecting diabetes:		
Authorization for DEC Medical Directives <input type="checkbox"/> Insulin Dose adjustments may be titrated by the Certified Diabetes Educator (CDE) according to current Medical Directive(s).		
OTHER RELEVANT HEALTH PROBLEMS <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 _____		
Family Physician: <hr/> Referring Health Care Professional:	Office Use: Stamp Date received at DEC	Office use only: Triage: Recent A1C: _____ % <input type="checkbox"/> Urgent <input type="checkbox"/> Team <input type="checkbox"/> 1-2 weeks <input type="checkbox"/> RN only <input type="checkbox"/> 2-3 weeks <input type="checkbox"/> RD only <input type="checkbox"/> 3-4 weeks Previous patient: Yes <input type="checkbox"/> No <input type="checkbox"/> Last seen at DEC: _____
Office use: Date contacted:		Appointment Date & Time: _____