Huron Perth Diabetes Program Referral
South Huron Hospital
Exeter Diabetes Program

Phone: 519 235-5175 Fax: 519 235-2945

NAME:	**Referral Date:** Day/month/year
ADDRESS:	**OHIP Number:**
CITY:	**DOB:** Day/month/year
PHONE # (H) **(C)**	

DIAGNOSIS: ☐ **Type 1** ☐ **Type 2** ☐ **Prediabetes** ☐ **Gestational** ☐ **Other**

NEW DIAGNOSIS: ☐ **YES** ☐ **NO** **DATE OF DIANOSIS:**

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

Reason for referral:

Other relevant health problems:

Recent blood work required for triage (i.e. HbA1C, Glucose, eGFR etc.)

DIABETES MEDICATIONS & INSULIN/GLP1:

* *If referred for insulin start please clearly indicate prescribed initial insulin regimen and preferred titration scheduled*

Authorization for Certified Diabetes Educators to use Medical Directives

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

Family Physician: **Referring Health Care Professional:**

Diabetes Team office use only

Stamp date received at DEC:	**Triage:** □ **Urgent** □ **Team** □ **1-2 weeks** □ **RN only** □ **2-4 weeks** □ **RD only** Previous patient: Yes □ No □ Last seen at DEC:	**Date(s) contacted :** **Scheduled appointment date & time:**