

<b>NAME:</b>	Referral Date: Day/month/year
<b>ADDRESS:</b>	<b>OHIP Number:</b>
<b>CITY:</b>	DOB: Day/month/year
<b>PHONE # (H) (C)</b>	
<b>DIAGNOSIS:</b> <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Prediabetes <input type="checkbox"/> Gestational <input type="checkbox"/> Other <b>NEW DIAGNOSIS:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>DATE OF DIANOSIS:</b>	
Currently self-glucose monitoring <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Reason for referral:</b>	
<b>Other relevant health problems:</b>	
<b>Recent blood work required for triage</b> (i.e. HbA1C, Glucose, eGFR etc.)	
<b>DIABETES MEDICATIONS &amp; INSULIN/GLP1:</b> <i>* If referred for insulin start please clearly indicate prescribed initial insulin regimen and preferred titration scheduled</i>	
<b>Authorization for Certified Diabetes Educators to use Medical Directives</b> <input type="checkbox"/> Insulin Dose adjustments may be titrated by the Certified Diabetes Educator according to current Medical Directive(s).	
<b>Family Physician:</b>	<b>Referring Health Care Professional:</b>
<b>Diabetes Team office use only</b>	
<b>Stamp date received at DEC:</b>	<b>Triage:</b> <input type="checkbox"/> Urgent <input type="checkbox"/> Team <input type="checkbox"/> 1-2 weeks <input type="checkbox"/> RN only <input type="checkbox"/> 2-4 weeks <input type="checkbox"/> RD only  Previous patient: Yes <input type="checkbox"/> No <input type="checkbox"/> Last seen at DEC:
	<b>Date(s) contacted :</b>  <b>Scheduled appointment date &amp; time:</b>