WaterlooWellington DIABETES.ca

REFERRAL FORM

Central Intake Fax: 1-855-DIABETS (342-2387) or 519-650-3114
Central Intake Phone: 1-844-204-9088 or 519-947-1000

Last Name: **First Name:** ☐ **M** ☐ **F** **DOB (dd/mm/yy):**
Address: **City:** **Postal Code:**
Telephone: D: E: **Language Barrier:** ☐ YES ☐ NO
Health Card Number: ☐ Aboriginal Status **Language Spoken:** ____________________
Primary Care Provider Name and Phone Number:

DIABETES ASSESSMENT (please check all that apply)

- ☐ URGENT
- ☐ Symptomatic
- ☐ New Diagnosis (<1 yr)
- ☐ Established (>1yr)
- ☐ Type 1
- ☐ Type 2
- ☐ Pre-diabetes
- ☐ Steroid induced
- ☐ High Risk for DM
- ☐ ____________
- ☐ No Previous Education

If **PREGNANT** check below:

☐ Type 1	☐ Repeat GDM	Due Date:
☐ Type 2	☐ High Risk	Hospital:
☐ GDM	☐ Postpartum	

REASON FOR REFERRAL (please check all that apply)

- ☐ Diabetes Education
- ☐ Poor Diabetes Control
- ☐ Hypoglycemia
- ☐ Pre-Pregnancy Counselling
- ☐ Weight Control
- ☐ Carb Counting
- ☐ Lipid Management
- ☐ Sick Day Management
- ☐ Insulin Start – See Order Below
- ☐ Insulin Pump
- ☐ CGMS
- ☐ GLP-1 Start: ____
- ☐ Insulin Adjustment Education
- ☐ Foot Care Education
- ☐ Foot Care Treatment
- ☐ Other (please specify)____

ORDERS FOR INSULIN INITIATION AND/OR ONGOING ADJUSTMENTS

Insulin Type:		☐ Adjust insulin dose by 1-2 units or up to 20% prn to achieve CDA CPG glycemic targets of ac 4-7 mmol/L and pc 5-10mmol/L or individual target of:______________________________
Dose and Time:		
Insulin Type:		☐ Adjust insulin dose by 1-2 units or up to 20% prn to achieve CDA CPG glycemic targets of ac 4-7 mmol/L and pc 5-10mmol/L or individual target of: ______________________________
Dose and Time:		

- ☐ Allow Certified Diabetes Educator to reduce the secretagogue dosage accordingly to avoid hypoglycemia
- ☐ Allow Certified Diabetes Educator to adjust carb/insulin ratios for self management of insulin therapy
- ☐ Allow Certified Diabetes Educator to order blood glucose or A1c for assessment and evaluation of glycemic control
- ☐ Allow Registered Dietitian to perform blood glucose monitoring with a meter

CURRENT THERAPY AND MEDICAL HISTORY

Check all that apply and include types and dosages
☐ **Insulin** ☐ **Antihyperglycemic Agents**

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- ☐ **History attached**
- ☐ Hypertension (>130/80)
- ☐ CVD
- ☐ PAD
- ☐ TIA/Stroke
- ☐ Retinopathy
- ☐ Nephropathy
- ☐ Exercise restrictions
- ☐ Neuropathy
- ☐ Vegetarian
- ☐ Psychosocial ____________
- ☐ Dyslipidemia
- ☐ Alcohol Use
- ☐ Sex Dysfunction
- ☐ Tobacco Use
- ☐ Foot ulcers
- ☐ Other ____________

LAB RESULTS (Please Record or Fax Copy)

Test	Result	Date	Test	Result	Date
FBS			Creatinine		
2hr OGTT			T Chol/HDL Ratio		
A1C			Triglycerides		
ACR			HDL Cholesterol		
eGFR			LDL Cholesterol		

- ☐ Endocrinologist/Specialist in Diabetes Consult ________________________
- ☐ Ophthalmologist Retinal Screening/Consult __________________________
- ☐ Nephrologist/HTN Clinic Consult __________________________

If requesting consult, provide your billing number ______________

Signature: ____ Date: ___________________________

Print Name: Phone: Fax:

Address (stamp):

For Internal Use ONLY
DEP:
Specialist:

For DEP Use ONLY
First Contact:
Appointment Dates: