Niagara North FHT

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# Diabetes Care Team Referral Form

**REASON FOR REFERRAL (Please include any specific concerns):**

☐ **TYPE 2 DIABETES** ☐ **PREDIABETES** ☐ **AT RISK**

*****No Type 1, Paediatric, Obstetrical or Pump Referrals -- Refer to Regional Diabetes Program*****

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Are there any factors which may affect learning:

☐ Language barriers ☐ Literacy concerns
☐ Visual impairment ☐ the need for individual vs group teaching

**PATIENT INFORMATION:**

First Name: _____
Last Name: _____
DOB (DD/MM/YYYY): _____
HC # and VC: _____
Phone: _____
Address: _____
City: _____
Postal Code: _____

**OR**
Place **Patient Label** here

***DATE OF DIAGNOSIS:** _____

**DIABETES MEDICATIONS:** _____

**OTHER MEDICATIONS:** _____

**Record Diagnostic Blood Sugar Values:** **FBS** _____ **A1C**_____ **DATE:** _____

*******ALL REFERRALS MUST INCLUDE: *******

- **A COPY OF MOST RECENT LAB REPORT**
- **MEDICAL HISTORY/CUMULATIVE PATIENT PROFILE**

**PHYSICIAN'S ORDER for INSULIN TITRATION:**

☐ **Insulin Initiation** **Type** _____ **Dose & Time** _____
**Type** _____ **Dose & Time** _____

☐ **Diabetes Educator will teach patient insulin dose adjustment by 1-2 units or 10-20% of total daily dose**

***SIGNATURE:** _____ **DATE:** _____

**REFERRING PROVIDER INFORMATION:**

Name: _____
Phone: _____
Fax: _____
Address: _____
City: _____
Postal Code: _____