NIAGARA NORTH Family Health Team

Diabetes Care Team
1338 Fourth Avenue (Suite S100), St. Catharines L2S 0G1
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www.niagaranorthfht.ca

Date: ______________________________

Self-Referral Form

Last Name:______________________________ First Name:______________________________

Date of Birth:____________________________ Gender:_______________________________

Address:____

Home Phone:_____________________________ Cell Phone: ____________________________

Family Doctor:______________________ Last appointment with doctor: ______________________

OHIP #__________________________________ Version Code: __________________________

Health & Diabetes Questions:

What type of diabetes do you have? ____

When were you diagnosed with diabetes? ____

How do you manage your diabetes (circle)? diet/exercise medication insulin other

When & where was your last lab work done? ____

Do we have permission to access your lab work (circle) ? Yes No **Signature:** _________________

When was your last eye exam? ____

Have you ever had a foot exam? ____

Please check any concerns you are having at this time with managing your diabetes:

- ☐ High Blood Sugars
- ☐ Low Blood Sugars
- ☐ High Blood Pressure
- ☐ Meal Planning
- ☐ Dental Problems
- ☐ Financial Pressures
- ☐ Constipation
- ☐ Diarrhea
- ☐ Vision Problems
- ☐ Leg and Foot Pain
- ☐ Smoking
- ☐ Alcohol

Please check off any of the following topics that you are interested in learning about:

- ☐ Meal Planning
- ☐ Reading Nutrition Labels
- ☐ Heart Healthy Eating
- ☐ Weight Management
- ☐ Physical Activity & Exercise
- ☐ Medic Alert Bracelet
- ☐ Foot Care
- ☐ Using your Glucometer
- ☐ Monitoring your Blood Sugars
- ☐ Medication Management