NIAGARA NORTH Family Health Team

Diabetes Care Team
1338 Fourth Avenue (Suite S100), St. Catharines L2S 0G1
Tel: 905.682.5555 Fax: 905.682.5585
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 diet/exercise medication insulin other

When & where was your last lab work done? _____

Do we have permission to access your lab work 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