Stand up to Diabetes

AN INTEGRATED DIABETES COMMUNITY

North Simcoe Muskoka

ADULT DIABETES EDUCATION CENTRAL REFERRAL FORM

COMPLETE ALL SECTIONS AND FAX TO **CENTRAL INTAKE: 705-325-4403**

REFER TO CENTRES WITH PEDIATRIC SERVICES (BARRIE / ORILLIA) FOR PATIENTS UNDER 18 YEARS OF AGE

PATIENT INFORMATION

(IF YOU HAVE A STICKER ENSURE THAT IT IS CLEAR AND IF NEED BE, OVERLAP THE TITLE ABOVE AND NOT PATIENT HEALTH QUESTIONS)

Name: ______________________ (First / Last) M ☐ F ☐ DOB: ____________ (Month / Day / Year)

Street Address: ______________________ City/Town ______________

Box/Mailing Address (if different): ______________________ Postal Code: ______________

OHIP # ______________________ Day Phone #: (   ) ______________

Email Address: ______________________ Evening Phone #: (   ) ______________

PATIENT HEALTH

Diagnosis: ☐ New Type 1 ☐ New Type 2 ☐ Pre-DM ☐ DM in Pregnancy/Gestational
☐ Previous Diagnosis Type 1 ☐ Previous Diagnosis Type 2 Year of Initial Diagnosis: ________ YEAR

DM Treatment: ☐ Lifestyle/Diet Only ☐ Oral Agents ☐ Insulin & Oral Agents
☐ Insulin Only ☐ Insulin Pump ☐ No Current Treatment

Complications: ☐ Cardiovascular Disease ☐ Nephropathy ☐ Neuropathy/Wound ☐ Retinopathy

Vascular Risks: ☐ BMI>40 ☐ Dyslipidemia ☐ Hypertension ☐ Smoking

Other: ☐ Disability/Physical Restriction ☐ Gastrointestinal ☐ Psychosocial ☐ Pre/Post Bariatric
☐ Mental Health Concern Other: ______________________

Comments:

REASON FOR REFERRAL

☐ Overall Education or Refresher — Key Topics Required: ______________________

☐ Transition from Youth to Adult Program — Paeds Program Attended: ______________________

☐ Inpatient/Emerg Follow-Up: — Inpt/Emerg Issue: ______________________

☐ Insulin Start (Additional info right): — Insulin Type: ______________________

Units: ______________ Frequency: ______________

Year patient last attended a DEP (Diabetes Education Program): ______________ (NIL if Never or YEAR)

REMEMBER to Attach **Labs & Med Lists**

CARE PROVIDERS

PCP Name: ______________________ PCP's Phone: ______________

Or check, ☐ Patient has no LOCAL Primary Care Provider and we will provide the patient with information for Health Care Connect.

Referring Provider Name: ______________________ Referring Organization/Hospital: ______________________

Signature: ______________________ Date: ______________

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