PATIENT NAME: ______________________________

DOB: ______________________________

HRN: ______________________________

Adult Diabetes Clinic Referral

Medicine Treatment Clinic

Phone: 705-728-9090 Ext: 23300

Fax: 705-797-2960

Patient Preferred contact number:________________

Patient Email Address:________________________

Purpose for Referral (select all that apply)

☐ New Diagnosis

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Gestational Diabetes ☐ Other: ____________________

☐ Medical Optimization

☐ Symptomatic Hyperglycemia ☐ Hypoglycemia ☐ Insulin Pump

Most recent A1C: ____________

Current Diabetes Medications:	**Other Medications (preference for typed attached document):**

Past Medical History (preference for typed attached document):
Additional Comments:

Signature of Referring Physician/NP: ____________________________ Date: ____________________

Referring Physician/NP Name (Print): ____________________________ Billing Number: ______________

Physician/NP Office Phone: ________________________ Physician/NP Office Fax: ______________________

For RVH Office Use:
Triage By: ______________________________________ Date: ____________________________
Action Plan: ____

RVH-2119 9-November-2023