Royal Victoria Regional Health Centre

Adult Diabetes Clinic Referral

Medicine Treatment Clinic
Phone: 705-728-9090 Ext: 23300
Fax: 705-797-2960

PATIENT NAME: _____
DOB: _____
HRN: _____
Phone Number: _____
Email Address: _____

Endocrinologist

☐ Dr. Alexa Clark

Purpose for Referral (select all that apply)

☐ New Diagnosis ☐ Medical Optimization

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

☐ 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: _____ Office Fax: _____

For RVH Office Use:

Triage By: _____ Date: _____

Action Plan: _____