WaterlooWellington DIABETES.ca

REFERRAL FORM
Central Intake Fax: 1-855-DIABETS (342-2387) or 519-620-3114
Central Intake Phone: 1-844-204-9088 or 519-947-1000

Last Name: **First Name:** ☐ M ☐ F ☐ X _____ **DOB (dd/mm/yy):**
Address: **City:** **Postal Code:**
Telephone: D: E: **Language Barrier:** ☐ YES ☐ NO
Health Card Number: ☐ Identifies as First Nations, Inuit, Metis **Language Spoken:** _____
Primary Care Provider Name and Phone Number:

DIABETES ASSESSMENT (please check all that apply)

☐ URGENT
☐ Symptomatic
☐ New Diagnosis (<1 yr)
☐ Established (>1yr)

☐ Type 1
☐ Type 2
☐ Pre-diabetes
☐ Steroid induced

☐ High Risk for DM
☐ _____
☐ No Previous Education

If **PREGNANT** check below:

☐ Type 1	☐ Repeat GDM	Due Date:
☐ Type 2	☐ High Risk	Hospital:
☐ GDM	☐ Postpartum	

REASON FOR REFERRAL (please check all that apply)

☐ Diabetes Education
☐ Poor Diabetes Control
☐ Experiencing Hypoglycemia
☐ Pre-Pregnancy Counselling
☐ Weight Control
☐ Carb Counting
☐ Lipid Management
☐ Sick Day Management
☐ Insulin Start – See Order Below
☐ Insulin Pump
☐ CGMS ☐ AGP/Flash
☐ GLP-1 Start – See Order Below
☐ Insulin Adjustment Education
☐ Foot Care Education
☐ Foot Care Treatment
☐ Other _____

_____

ORDERS FOR INSULIN and/or GLP-1 INITIATION AND/OR ONGOING ADJUSTMENTS

Insulin Type:		☐ Adjust insulin dose by 1-2 units or up to 20% prn to achieve Diabetes Canada CPG glycemic targets of ac 4-7 mmol/L and pc 5-10mmol/L or individual target of: _____ or ☐ Adjust insulin by:
Dose and Time:		
Insulin Type:		☐ Adjust insulin dose by 1-2 units or up to 20% prn to achieve Diabetes Canada CPG glycemic targets of ac 4-7 mmol/L and pc 5-10mmol/L or individual target of: _____ or ☐ Adjust insulin by:
Dose and Time:		
GLP-1: Type/Dose and Time:		☐ Adjust GLP-1 by: _____

☐ Allow Certified Diabetes Educator to reduce the secretagogue dosage accordingly to avoid hypoglycemia
☐ Allow Certified Diabetes Educator to adjust carb/insulin ratios for self management of insulin therapy

CURRENT THERAPY AND MEDICAL HISTORY

Check all that apply and include types and dosages
☐ **Insulin** ☐ **Antihyperglycemic Agents**

☐ **History attached**
☐ Hypertension
☐ CVD
☐ PAD
☐ Dyslipidemia
☐ TIA/Stroke
☐ Fatty Liver
☐ Retinopathy
☐ Nephropathy
☐ Neuropathy
☐ Gastroparesis
☐ Vegetarian
☐ Mental Health: _____
☐ Obesity
☐ Exercise restrictions
☐ Alcohol Use
☐ Tobacco Use
☐ Sexual Dysfunction
☐ Foot ulcers
☐ _____

Test	Result	Date	Test	Result	Date
FBS			Creatinine		
2hr OGTT			T Chol/HDL Ratio		
A1C			Triglycerides		
ACR			HDL Cholesterol		
eGFR			LDL Cholesterol		

☐ Endocrinologist/Specialist in Diabetes Consult _____ ☐ Nephrologist/HTN Clinic Consult _____
☐ Ophthalmologist Retinal Screening/Consult _____
☐ Medically Supervised Wound Care Consult _____ ***If requesting consult, provide your billing number*** _____

Signature: _____ Date: _____
Print Name: Phone: Fax:
Address (stamp):

Save Referral | Print Referral | Clear Form

For Internal Use ONLY
DEP:
Specialist:

For DEP Use ONLY
First Contact:
Appointment Dates: