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
- ☐ 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
- ☐ Retinopathy
- ☐ Nephropathy
- ☐ Neuropathy
- ☐ Gastroparesis
- ☐ Vegetarian
- ☐ Psychosocial ______________
- ☐ Exercise restrictions
- ☐ Alcohol Use
- ☐ Tobacco Use
- ☐ Sexual Dysfunction
- ☐ Foot ulcers
- ☐ Other ________________

| 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 ______________________

☐ Ophthalmologist Retinal Screening/Consult ________________________ **If requesting consult, provide your billing number* _____________

☐ Nephrologist/HTN Clinic Consult _________________________

Signature: ____________________________________ Date: _________________________

Print Name: Phone: Fax:

Address (stamp):

**For Internal Use ONLY**
**DEP:**
**Specialist:**

**For DEP Use ONLY**
**First Contact:**
**Appointment Dates:**