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: _____

Ontario