

Last Name: _____ **First Name:** _____ M F **DOB (dd/mm/yy):** _____
Address: _____ **City:** _____ **Postal Code:** _____
Telephone: D: _____ **E:** _____ **Language Barrier:** YES NO
Health Card Number: _____ Aboriginal Status **Language Spoken:** _____
Primary Care Provider Name and Phone Number: _____

DIABETES ASSESSMENT (please check all that apply)

URGENT Type 1 High Risk for DM **If PREGNANT check below:**
 Symptomatic Type 2 _____ Type 1 Repeat GDM **Due Date:** _____
 New Diagnosis (<1 yr) Pre-diabetes No Previous Type 2 High Risk **Hospital:** _____
 Established (>1yr) Steroid induced Education GDM Postpartum

REASON FOR REFERRAL (please check all that apply)

Diabetes Education Weight Control Insulin Start – See Order Below Insulin Adjustment Education
 Poor Diabetes Control Carb Counting Insulin Pump Foot Care Education
 Hypoglycemia Lipid Management CGMS Foot Care Treatment
 Pre-Pregnancy Counselling Sick Day Management GLP-1 Start: _____
 Other (please specify) _____

ORDERS FOR INSULIN INITIATION AND/OR ONGOING ADJUSTMENTS

Insulin Type:		<input type="checkbox"/> Adjust insulin dose by 1-2 units or up to 20% prn to achieve Diabetes Canada CPG glyemic targets of ac 4-7 mmol/L and pc 5-10mmol/L or individual target of: _____
Dose and Time:		
Insulin Type:		<input type="checkbox"/> Adjust insulin dose by 1-2 units or up to 20% prn to achieve Diabetes Canada CPG glyemic targets of ac 4-7 mmol/L and pc 5-10mmol/L or individual target of: _____
Dose and Time:		
<input type="checkbox"/> Allow Certified Diabetes Educator to reduce the secretagogue dosage accordingly to avoid hypoglycemia		
<input type="checkbox"/> Allow Certified Diabetes Educator to adjust carb/insulin ratios for self management of insulin therapy		
<input type="checkbox"/> Allow Certified Diabetes Educator to order blood glucose or A1c for assessment and evaluation of glyemic control		
<input type="checkbox"/> Allow Registered Dietitian to perform blood glucose monitoring with a meter		

CURRENT THERAPY AND MEDICAL HISTORY

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

History attached Nephropathy Dyslipidemia
 Hypertension Exercise restrictions Alcohol Use
 (>130/80) Neuropathy Sex Dysfunction
 CVD Vegetarian Tobacco Use
 PAD Psychosocial Foot ulcers
 TIA/Stroke Retinopathy Other

LAB RESULTS (Please Record or Fax Copy)

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 _____
 Nephrologist/HTN Clinic Consult _____ **If requesting consult, provide your billing number _____*

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

For Internal Use ONLY

DEP: _____
Specialist: _____

For DEP Use ONLY

First Contact: _____
Appointment Dates: _____