Diabetes Education Referral Form

Phone: (519) 661-1600 Fax: (519) 661-1634

Diabetes Education Centre
of St. Joseph's Health Care London
P.O. Box 5777
London, Ontario N6A 4L6

DATE:

Ms/Miss/Mrs/Mr/Dr _____ **D.O.B** Y____M____D____

Address_____Postal Code:_____ **J#**_____

Phone # Home: _____Cell: _____Work: _____ **OHC#**_____

Most patients will be seen in groups unless barrier identified. ARE THERE ANY BARRIERS? Please circle: Vision Hearing Low Literacy Behavioural/Mental Health
Additional medical/social considerations (e.g. Dialysis)
Language Barrier (speaks_____) Interpreter Required ☐

CHOOSE ONE: **BOOKINGS MAY BE DELAYED IF ALL SECTIONS ARE NOT COMPLETED**

☐ **Prediabetes (FBS 6.1-6.9 or 2 hr 7.8-11.0) (All Prediabetic Patients Will Be Seen in Groups)**

☐ **Type 2 Diabetes (FBS ≥ 7.0 &/or Random BG ≥ 11.1 or A1C ≥ 6.5 %).**

☐ **Type 1 Diabetes**

☐ **Other _____**

Date of Diagnosis_____

☐ **BLOODWORK ATTACHED (A1c, FBS, LDL, TC/HDL ratio, ACR, eGFR)**

Current DIABETES Medications:

☐ **INSULIN START (INSULIN ORDERS MUST BE COMPLETED IF THIS IS AN INSULIN START)**

☐ **Script: Physician has given patient script for insulin, needles and testing supplies.**

☐ **Insulin Orders:**
_____ units of _____ insulin at breakfast
_____ units of _____ insulin at lunch
_____ units of _____ insulin at supper
_____ units of _____ insulin at bedtime (before hs snack)
_____ units of _____ insulin at _____(other)

☐ **Adjustment of insulin: (choose one)**
_____ Patient to call Referring physician for all insulin adjustment
_____ Patient to follow-up with Referring physician AND may be instructed to adjust insulin by 2 units OR 10% for high blood sugars pattern. (Patient will be instructed to adjust based on 3 days pattern of consistent high blood sugars if the patient demonstrates understanding of insulin action and the recognition and treatment of low blood sugar).

☐ **Oral Diabetes Medications**
Choose one:
_____ No changes to orals once insulin started OR _____ Once insulin started, change oral medications as follows:
_____

Physician Referring:
Name: Address:
Phone #: **FAX #:**
Signature of Referring Physician:

Other Physician Provider

Appointment with **RN**_____ **RD**_____ **Group** _____