Diabetes Education Referral Form

Phone: 519.661.1600
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Diabetes Education Centre
of St. Joseph's Health Care London
P.O. Box 5777, Stn. B., London, Ontario, N6A 4V2

DATE:

Ms/Miss/Mrs/Mr _____ D.O.B. YYYY _____ MM _____ DD _____
Address: _____ Postal Code _____ J# _____
Preferred contact number Mobile _____ Other _____
Ontario Health Card# _____ Version Code _____

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 _____

****BOOKINGS MAY BE DELAYED IF ALL SECTIONS ARE NOT COMPLETED****

Date of Diagnosis _____

CHOOSE ONE:

- ☐ 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 _____

☐ 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 blood glucose monitoring 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 only 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 sugar 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 only one)
  - ☐ No changes to orals once insulin started
  - ☐ Once insulin started, change oral medications as follows: _____

_____

Physician Referring:
Name:_____ Address:_____
Phone:_____ FAX:_____
Signature of Referring Physician: _____

Other Physician Provider

In office use only - Appointment with **RN** _____ **RD** _____ **Group** _____

(Form Revised 2020/10/13