Primary Care Diabetes Support Program: What health care professionals can expect

Effective diabetes management requires that patients have access to an ongoing course of self-care support, which is critical to enable them to effectively manage their disease and prevent its devastating complications.

Teamwork, continuity of care, electronic monitoring, advocacy, community outreach, addressing the social determinants of health through community and social service partnerships, and seamless access to the full continuum of diabetes care are all hallmarks of the Primary Care Diabetes Support Program.

We provide shared care for health professionals providing support for diabetes patients with complex self-care challenges, such as mental illness, economic hardship, language barriers, social isolation, and complex medical issues.

Through the Primary Care Diabetes Support Program, patients make great gains. Within months, our goal is to support patients to achieve the recommended targets for blood sugar, blood pressure and cholesterol.

To refer a patient

To refer a patient to the Primary Care Diabetes Support Program, fax brief referral information to 519 645-6961.

There is no billing impact to family physicians referring to the Primary Care Diabetes Support Program. Our physicians have alternate billing status.

Diabetic Foot Ulcer Risk Stratification & Referral (FURST) tool

The purpose of the diabeteic foot referral tool is to guide you, as a healthcare professional, in building your patients 'dream team', as it relates to their level of diabetic foot risk. Learn more and access the FURST tool on the South West Regional Wound Care Program website.

To learn how to use the tool, please access the FURST e-learning module