

***Majority of our physicians have GP focused practice designation. If you are a rostered model practice, WE'LL DO OUR BEST to book your patient with one of our focused practice designated physicians. ***
Please circle: FHO or FHN

PRIMARY CARE DIABETES SUPPORT PROGRAM REFERRAL FORM

Please complete all **FOUR** sections, **ATTACH** all related documents and **FAX** to the PCDSP at **519-645-6961**.

1. PATIENT INFORMATION Affix LABEL or complete:	2. REFERRING PHYSICIAN
Name: _____ J#/PIN: _____ Gender: _____ Date of Birth: _____ Health Card #: _____ Telephone #: _____ Family Physician: _____	<i>Please print or use a stamp:</i>

3. MANDATORY – PRIMARY REFERRAL CRITERIA – TYPE 2 DIABETES , A1c <u>>8%</u> <u>AND</u> <i>Patients must meet ONE of the following criteria (check A, B or C):</i>		
<input type="checkbox"/> A. No Primary Care Provider (family physician, NP)	<input type="checkbox"/> B. CKD with eGFR <60	<input type="checkbox"/> C. On <u>maximally tolerated</u> glycemic regimen (DPP4i, SGLT2i, Metformin, SU etc.)

4. PATIENT / TREATMENT HISTORY AND INVESTIGATIONS: EHR/EMR summary	
Duration of T2DM: Brief history of recent glycemic Regimen:	Supporting Documents: <i>Send copies of the following, if not available on Power chart:</i> <ul style="list-style-type: none"> <input type="checkbox"/> Health History or Cumulative Patient profile <input type="checkbox"/> Recent laboratory investigations including: CBC, A1c, Electrolytes, eGFR, Serum Creatinine, ACR, ALT <input type="checkbox"/> Most recent Cardiac assessment i.e. EKG, Cardiology consult note <input type="checkbox"/> Medication list <input type="checkbox"/> ABPI <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Additional notes: _____

_____ *Thank you for your referral!*

Date: _____ *Please ensure contact information is current.*