

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 , A1cv \geq 7.5% <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> glycemc regimen (DPP4, SGLT2, Metformin, SU etc.)	

4. PATIENT / TREATMENT HISTORY AND INVESTIGATIONS: EHR/EMR summary	
Duration of T2DM: Brief history of recent glycemc Regimen: 	Supporting Documents: <i>Send copies of the following, if not available on Powerchart:</i> <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 ie 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.*