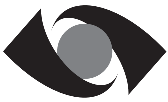

SOUTHLAKE
REGIONAL HEALTH CENTRE

The Tannery Mall
465 Davis Drive, Suite 213
Newmarket, ON L3Y 2P1
Tel: 905-895-4521, ext. 5650 | Fax: 905-853-3180

Health Record #: ____________ Complete or place barcoded patient label here
Patient Name: (Print first, last) ____________
DOB: dd / mm / yy Age: ______ ❑ Female ❑ Male
OHIP #: ____________ Version Code: ____________
Account #: ____________ Date of Admission: dd / mm / yy

Diabetes Education Program (DEP) Referral Form

Patient's Name: (print first, last) | Allergies: ❑ NKA

Language preferred, if not English: | Primary Phone: | Secondary Phone:

Reason for Referral:
- ❑ Diabetes Education
- ❑ Insulin/GLP-1 Analog Start (write order/attach Rx and sign below)
- ❑ Inpatient/ER follow-up
- ❑ Pre-pregnancy planning - ❑ Type 1 ❑ Type 2
- ❑ OTN Diabetes Education consult
- ❑ ____________

Type of Diabetes:
- ❑ At risk
- ❑ Prediabetes ❑ newly diagnosed OR year diagnosed:______
- ❑ Type 2 – ❑ newly diagnosed OR year diagnosed:______
- ❑ Type 1 – ❑ newly diagnosed OR year diagnosed:______
- ❑ Pregnant with gestational diabetes ______weeks
- ❑ Pregnant with ❑ Type 1 ❑ Type 2 ______weeks

Insulin or GLP-1 Analog Order:	Dose:	Time:

❑ Continue current diabetes oral medications ❑ Stop these after insulin/GLP-1 Analog start:

Current Medications:	Dose	Route	Freq.	Current Medications:	Dose	Route	Freq.

Additional Considerations:
❑ Hypertension ❑ Dyslipidemia ❑ Cardiovascular disease ❑ Foot ulcer ❑ Nephropathy ❑ Neuropathy ❑ Retinopathy
❑ Other: ____________

Laboratory Results: Please attach all recent blood work (including HbA1C, lipid profile, FPG, OGTT, etc.) ❑ Attached

Referring Health Care Provider Information:
A report of the visit will be provided to:
Name: ____________
Address: ____________
Phone: ____________ Fax: ____________
Billing number: ____________

Physician Orders:
1. **I authorize the Diabetes Educator/s to adjust this patient's insulin based on the DEP's Medical Directive** (available from the DEP). The Diabetes Educator will provide education on how to self-titrate insulin based on blood glucose, carbohydrate intake and physical activity. ❑ Yes ❑ No
2. **I authorize an Endocrinologist to see this patient on an urgent basis IF AVAILABLE ON SITE.** ❑ Yes ❑ No

MD Name: (print first, last) ____________ **Discharge Time:** ____________
Signature: ____________ **Date:** dd / mm / yy

Source: Adapted from Central LHIN Diabetes Education Program Referral Form