

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: <i>(print first, last)</i> _____				Allergies: _____ <input type="checkbox"/> NKA			
Language preferred, if not English: _____			Primary Phone: _____		Secondary Phone: _____		
Reason for Referral: <input type="checkbox"/> Diabetes Education <input type="checkbox"/> Insulin/GLP-1 Analog Start <i>(write order/attach Rx and sign below)</i> <input type="checkbox"/> Inpatient/ER follow-up <input type="checkbox"/> Pre-pregnancy planning - <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> OTN Diabetes Education consult <input type="checkbox"/> _____				Type of Diabetes: <input type="checkbox"/> At risk <input type="checkbox"/> Prediabetes <input type="checkbox"/> newly diagnosed OR year diagnosed: _____ <input type="checkbox"/> Type 2 – <input type="checkbox"/> newly diagnosed OR year diagnosed: _____ <input type="checkbox"/> Type 1 – <input type="checkbox"/> newly diagnosed OR year diagnosed: _____ <input type="checkbox"/> Pregnant with gestational diabetes _____ weeks <input type="checkbox"/> Pregnant with <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 _____ weeks			
Insulin or GLP-1 Analog Order:		Dose:			Time:		
<input type="checkbox"/> Continue current diabetes oral medications <input type="checkbox"/> Stop these after insulin/GLP-1 Analog start:							
Current Medications:	Dose	Route	Freq.	Current Medications:	Dose	Route	Freq.
Additional Considerations: <input type="checkbox"/> Hypertension <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Cardiovascular disease <input type="checkbox"/> Foot ulcer <input type="checkbox"/> Nephropathy <input type="checkbox"/> Neuropathy <input type="checkbox"/> Retinopathy <input type="checkbox"/> Other: _____							
Laboratory Results: Please attach all recent blood work <i>(including HbA1C, lipid profile, FPG, OGTT, etc.)</i> <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No 2. I authorize an Endocrinologist to see this patient on an urgent basis IF AVAILABLE ON SITE. <input type="checkbox"/> Yes <input type="checkbox"/> No							
MD Name: <i>(print first, last)</i> _____				Discharge Time: _____			
Signature: _____				Date: <u>dd</u> / <u>mm</u> / <u>yy</u>			

