Windsor Essex Community Health Centre
Centre de santé communautaire de Windsor Essex
weCHC
Healthcare for You
Des soins de santé pour vous

# DIABETES WELLNESS REFERRAL FORM

**Please fax this form to: 226-216-5174**

Patient Name: _____ DOB (dd/mm/yyyy): _____ ☐ Male ☐ Female

Address: _____ Postal Code: _____

Home Phone: _____ Health Card: _____ ___

Cell Phone: _____ Language Spoken: _____ Interpreter Needed: ☐ Yes ☐ No

**Type Of Diabetes (please check all that apply)**

☐ New Diagnosis (<6 months) ☐ Established (>6 months) ☐ Pre-diabetes ☐ Type 1 ☐ Type 2

**Reason For Referral (please check all that apply)**

☐ **Urgent (24-48 hrs)**
☐ Insulin Start (see order below)
☐ Meter Teach
☐ Support / Education for Self-Management of Insulin Adjustment
☐ **HBA1c:** _____
☐ GLP1 Initiation
☐ CGM initiation
☐ Diabetes Education
☐ Insulin Pump Therapy
☐ Foot Care Education
☐ Nutrition

**Present Diabetes Management & Medical History (please attach any pertinent labs or medication list)**

☐ CKD (eGFR_____) ☐ CAD ☐ Retinopathy ☐ Neuropathy

☐ **Notes / Medications / Other:**

**Orders for Insulin Initiation and/or Ongoing Adjustments**

| | | |
|---|---|---|
| Insulin Type: | | ☐ Adjust insulin dose by 1-2 units or up to 15% prn to achieve DC CPG glycemic targets for ac 4-7 mmol/L and pc 5-10 mmol/L or individual target of: _____ |
| Dose & Time: | | |
| Insulin Type: | | ☐ Adjust insulin dose by 1-2 units or up to 15% prn to achieve DC CPG glycemic targets for ac 4-7 mmol/L and pc 5-10 mmol/L or individual target of: _____ |
| Dose & Time: | | |

☐ Allow Certified Diabetes Educator to reduce the secretagogue dosage accordingly to avoid hypoglycemia
☐ Allow Certified Diabetes Educator to adjust care/insulin ratios for self-management of insulin therapy
☐ Allow Certified Diabetes Educator to order blood glucose or A1c for assessment/evaluation of glycemic control

**Referring Person / Physician / Nurse Practitioner (NP):**

Signature: _____ Print Name: _____ Date: _____
*(Signature required only for medical orders)* (dd/mm/yyyy)

Primary Care Provider / Endocrinologist (if different from referring NP/ physician): _____

**Referring Physician/Person Has a Preferred Site for Service – Please Check Program Choice Below**

☐ Diabetes Wellness
2885 Lauzon Pkwy.

☐ Leamington
33 Princess St.

☐ Sandwich
3325 College Ave.

☐ Street Health
711 Pelissier St.