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): _____

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:** _____
☐ GLP-1/GIP 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 Anti-Hyperglycemic agent (AHA) 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 adjust GLP-1/GIP to manage GI symptoms & sick day management		
☐ 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.