



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) HBA1c: _____ Diabetes Education
 Insulin Start (see order below) GLP-1/GIP Initiation Insulin Pump Therapy
 Meter Teach CGM initiation Foot Care Education
 Support / Education for Self-Management of Insulin Adjustment 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:		<input type="checkbox"/> Adjust insulin dose by 1-2 units or up to 15% prn to achieve DC CPG glyceic targets for ac 4-7 mmol/L and pc 5-10 mmol/L or individual target of: _____
Dose & Time:		
Insulin Type:		<input type="checkbox"/> Adjust insulin dose by 1-2 units or up to 15% prn to achieve DC CPG glyceic targets for ac 4-7 mmol/L and pc 5-10 mmol/L or individual target of: _____
Dose & Time:		
<input type="checkbox"/> Allow Certified Diabetes Educator to reduce the secretagogue dosage accordingly to avoid hypoglycemia		
<input type="checkbox"/> Allow Certified Diabetes Educator to adjust care/insulin ratios for self-management of insulin therapy		
<input type="checkbox"/> Allow Certified Diabetes Educator to adjust GLP-1/GIP to manage GI symptoms & sick day management		
<input type="checkbox"/> Allow Certified Diabetes Educator to order blood glucose or A1c for assessment/evaluation of glyceic 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. Downtown 1200 University Ave. W