

DIABETES WELLNESS REFERRAL FORM

Please fax this form to: 226-216-5174



Patient Last Name: _____ First Name: _____ DOB (dd/mm/yyyy): _____

Address: _____ Postal Code: _____

Home Phone: _____ Health Card: _____ ☐ Male ☐ Female ☐ Other: _____

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

Referral Status: ☐ Urgent (24-48 hrs) ☐ Semi-Urgent (1 week) ☐ Routine

Type Of Diabetes: (please check all that apply)

- | | | | |
|--|--------------------------------------|--|---|
| ☐ New Diagnosis (<6 months) | ☐ Prediabetes | ☐ Pregnant | ☐ Gestational Diabetes |
| ☐ Established (>6 months) | ☐ Type 1 | Due Date: _____ # of Weeks: _____ | |
| | ☐ Type 2 | ☐ OGTT: 1 hr _____ 2 hr _____ | |

Reason For Diabetes Referral (please check all that apply)

- | | | |
|--|--|--|
| ☐ GLP-1/GIP Initiation | ☐ Insulin Pump Therapy | ☐ Type 1 Diabetes (T1D) Antibody Testing - Specify Criteria Met:
☐ Family Hx of T1D
☐ Hx of Auto-immune Disease
☐ Query T1D versus T2D |
| ☐ Meter Teach | ☐ CGM initiation | |
| ☐ Self-Management of Insulin Adjustment | ☐ Nutrition Education | |
| ☐ Insulin Start (see order below) | ☐ Self-Management | |
| ☐ Therapeutic Exercise Class / Program | ☐ Diabetes Foot Care Workshop | |

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

- ☐ HBA1c: _____% ☐ CKD(eGFR: _____) ☐ 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 GLP-1/GIP to manage GI symptoms & sick day management		
☐ Allow Certified Diabetes Educator to administer 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:

- | | | | |
|---|--|---|--|
| ☐ Diabetes Wellness / East Windsor
2885 Lauzon Pkwy, Unit 107 | ☐ Leamington
33 Princess Street, Suite 450 | ☐ Sandwich
3325 College Ave | ☐ Downtown
1200 University Ave W |
|---|--|---|--|