



**Diabetes Education Care (DEC)
 REFERRAL FORM**

FORM PS307

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Rev. 05/2020

Patient LABEL / Identification Area

UNIT E7, 2 CHAMPAGNE DRIVE, TORONTO, ON, M3J 0K2 TEL:416-756-6923 FAX: 416-756-6329

Patient name: _____
 Height: _____ Telephone #: Home _____ Work _____ Cell _____
 Weight: _____ Email Address: _____

REASON FOR REFERRAL: (The patient will be seen by a multidisciplinary team)

- Newly Diagnosed BG Control Insulin Administration Diet
 Hypoglycemia Self BG Monitoring Therapy Adjustment Start MDI

HISTORY
 Diabetes Type: 1 2 Gestational IFG IGT Date of diagnosis: _____
 Coronary Artery Disease Neuropathy Hypertension Obesity
 Peripheral Vascular Disease Retinopathy Dyslipidemia Symptomatic
 Cerebral Vascular Disease Nephropathy Foot/Skin Problems Erectile Dysfunction
 Other

SIGNIFICANT MEDICAL HISTORY:

LAB DATA/ <input type="checkbox"/> attached	Date	FBG	RBG	HbA1C	CHOL	HDL	LDL	TRIG	ALT	Creatinine	Microalbumin/ Creatinine ratio

GESTATIONAL GTT _____ gm FBG _____ 1hr _____ 2hr _____ EDC _____

MEDICATIONS
 Current To be initiated
 Diabetes:

 Other:

DIET
 Restrictions:
 Low Cholesterol Low Sodium Low Protein Alcohol Others _____

Your signature authorizes the dietitian to alter meal plan as required and the nurse to administer and adjust diabetes medication according to the medical directive approved by North York General Hospital.
 Summary/ Progress Reports will be sent. Patients are expected to return to their family physician.

_____ Referring Physician Signature Date: _____	Name, mailing address, telephone & fax: (please print or stamp clearly) Send additional reports to:
-------------------------------------------------------	--------------------------------------------------------------------------------------------------------------

DATE	TIME (24 h)	SIGNATURE	PRINT NAME