Bancroft Community
Family Health Team

DIABETES EDUCATION PROGRAM - REFERRAL

Is this an URGENT Referral? ___No ___Yes

Name_____

Address_____

_____

HCN _____

D.O.B _____PHONE:_____

Reason for Referral:

☐ Prediabetes

☐ Type 1 Diabetes

☐ Type 2 Diabetes

☐ Gestational Diabetes

☐ Insulin start – Call 613-332-1565 ext 261 to confirm receipt of referral

Insulin prescribed: _____ Starting dose: _____

If fasting blood glucose (FBG) remains above target:

☐ Increase dose by _____ units every _____ days until FBG <7.0 mmol/L

OR

☐ Increase dose based on Certified Diabetes Educators' (CDE) recommendations following Diabetes Canada guidelines.

*FOR THE MANAGEMENT OF INSULIN FOR DIABETES:
Do you give permission for the CDEs in the Diabetes Education Program to provide insulin dose adjustments by no more than 20% in response to hyperglycemia or hypoglycemia?

☐ Yes ☐ No

Please inform patients to BRING ALL MEDICATIONS to the first appointment.

PLEASE INCLUDE MOST RECENT BLOODWORK WITH REFERRAL

REFERRING PROVIDER: _____ Date: _____

Family Physician or Primary Care Provider (if different): _____

Referring Provider's signature: _____

FAX: 613-332-5541