



The following patients should be referred to Endocrinology or a hospital Diabetes Education Centre:
 Patients newly diagnosed with Type1 or have unstable Type 1 Diabetes
 Patients with Gestational Diabetes requiring insulin management
 Pediatric patients < 19 yrs

Diagnosis

- Pre-Diabetes Type 1 Type 2
 Gestational: _____ Weeks Other _____
 This patient is Newly Diagnosed
 Established _____ year(s)

Name: _____
 Address: _____

 HCN: _____
 D.O.B.: _____ Phone: _____

PAST/PRESENT HEALTH PROBLEMS

Hypertension Nephropathy Retinopathy Neuropathy Dyslipidemia Pancreatitis OSA
 Coronary Artery Disease Mental Health Diagnosis Pancreatitis Other _____

Reason for Referral

Is this an **URGENT** referral? Yes No

- For an Insulin Start- Call 613-332-1565 Ext 220 to confirm receipt of referral
 Basal Insulin Prescribed: _____ Starting Dose: _____ units
 Please increase by _____ units every _____ day(s) until fbg target of _____ mmol/L.
 Other insulin Prescribed: _____ Frequency: _____
 Directions: _____
 For Education and Diabetes Management

If client is on insulin my signature below authorizes the diabetes educator to direct patient to adjust insulin as per the Diabetes Canada Clinical Practice Guidelines

I decline diabetes educator making insulin adjustments

The client is aware of this Referral Yes No

Healthcare Provider

Referring Provider: _____ Phone: _____

Referring Provider's Signature: _____ Date: _____

Primary Care Provider if different from above: _____

*PLEASE ATTACH A LIST OF THE **CURRENT MEDICATIONS** THE PATIENT IS ON & ASK THEM TO BRING THEM TO THE APPOINTMENT

*PLEASE ATTACH PATIENTS MOST RECENT **LAB WORK**- include most recent HBA1C (if possible within the last 6 months)

PLEASE FAX REFERRAL TO 613-332-5541