

Toronto Central Diabetes Education Program Referral Form for Type 2 diabetes and Prediabetes

Individuals with type 1 diabetes and/or who are currently pregnant should be referred to an endocrinologist as soon as possible.

Name: _____ Gender _____ Aboriginal
 Address: _____ Date of Birth (dd/mm/yyyy): _____ / _____ / _____
 City: _____ Postal Code: _____ Daytime Contact Phone #: _____
 Client prefers to attend Diabetes Education Program closest to (intersection): _____

Does the client identify with any of these challenges? (Check all that apply)

non-insured (refugee, new immigrant)
 mental health challenges (explain): _____
 homeless/marginally housed
 problematic drug and/or alcohol use
 mobility issues
 developmental challenges
 no family doctor/nurse practitioner

Language(s) Spoken: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other: _____ <input type="checkbox"/> Interpreter required	Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other: _____
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Referred for (check all that apply):

Diabetes Self-Management Support
 Education
 Insulin initiation

Client is appropriate for group education If not, please indicate why. _____

Diagnosis: Type 2 Prediabetes Newly Diagnosed (within 6 months)

Medical History:

Cardiovascular Disease Neuropathy
 Dyslipidemia Foot/Wound Concerns
 Hypertension Previous GDM
 Renal Disease Other: _____
 Retinopathy _____

Laboratory data *attach lab reports if preferred*

Date: _____

FPG		LDL		A1C	
PG		TC/HDL		ACR	
OGTT		TG		eGFR	

Medications *attach med list if preferred*

Current Diabetes Medications:	Other Medications:
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Orders for Insulin Initiation <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 30%;">Insulin Type:</td><td style="width: 70%;"></td></tr> <tr><td>Dose and Time:</td><td></td></tr> <tr><td>Insulin Type:</td><td></td></tr> <tr><td>Dose and Time:</td><td></td></tr> </table> <input type="checkbox"/> Diabetes Educator may teach client insulin dose adjustment by 1-2 units or up to 10% of total daily insulin dose Physician's signature (required): _____	Insulin Type:		Dose and Time:		Insulin Type:		Dose and Time:		Referred by: _____ Phone: _____ Fax: _____ <p style="text-align: center;">Referring physicians and nurse practitioners will receive a complete report of the assessment and education provided to the client.</p>
Insulin Type:									
Dose and Time:									
Insulin Type:									
Dose and Time:									