



Diabetes Education Centre Referral
Huron Perth Healthcare Alliance
 Stratford General Hospital St. Marys Memorial Hospital
 Seaforth Community Hospital Clinton Public Hospital
Phone: 519 272-8210 ext. 2365 Fax: 519 272-8188



NAME		Referral Date	
ADDRESS		Date of Diagnosis	
Phone # (h) _____ (cell) _____ (w) _____		DOB Day/month/year	
Phone Number can be reached at during day: _____		OHIP Number	
REASON FOR REFERRAL – comments/special instructions			
Diagnosis: <input type="checkbox"/> New <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> IGT/IFG <input type="checkbox"/> Gestational			
Currently does self-glucose monitoring <input type="checkbox"/> Yes <input type="checkbox"/> No			
ATTACH RECENT BLOOD WORK – within past 3 months (i.e. HbA1C, Lipids, Glucose, etc.)			
****Referrals will not be accepted without supporting lab documents. ****			
MEDICATIONS: <i>If referred for insulin start please clearly indicate prescribed initial insulin regimen and have patient fill prescription at the drug store and bring along to insulin start session.</i>			
Other medications/conditions affecting diabetes:			
Authorization for DEC Medical Directives			
<input type="checkbox"/> Insulin Dose adjustments may be titrated by the Certified Diabetes Educator (CDE) according to current Medical Directive(s).			
OTHER RELEVANT HEALTH PROBLEMS			
<input type="checkbox"/> High Risk Feet <input type="checkbox"/> Hypertension <input type="checkbox"/> Nephropathy <input type="checkbox"/> Neuropathy <input type="checkbox"/> Overweight <input type="checkbox"/> Psychosocial <input type="checkbox"/> Retinopathy <input type="checkbox"/> Smoker <input type="checkbox"/> Other _____ <input type="checkbox"/> Coronary <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Exercise Restrictions			
Family Physician:	Office Use: Stamp Date received at DEC	Office use only: Triage: <input type="checkbox"/> Urgent <input type="checkbox"/> Team <input type="checkbox"/> 1-2 weeks <input type="checkbox"/> RN only <input type="checkbox"/> 2-3 weeks <input type="checkbox"/> RD only <input type="checkbox"/> 3-4 weeks Previous patient: Yes <input type="checkbox"/> No <input type="checkbox"/> Last seen at DEC: _____	
Referring Health Care Professional:	Site: <input type="checkbox"/> Stratford <input type="checkbox"/> Seaforth <input type="checkbox"/> St. Marys		
Office use: Date contacted:		Appointment Date & Time: _____	