Huron Perth Diabetes Education Program

Referral Form

Wingham & District Hospital

Phone: 519 357-3210 Ext. 5273
Fax: 519 357-3928

NAME	**Referral Date**
ADDRESS	**Date of Diagnosis**
Phone # (h) _____ (cell) _____ (w)_____ **Phone Number can be reached at during day: _____**	**DOB** Day/month/year

REASON FOR REFERRAL – comments/special instructions

Diagnosis: ☐ **New** ☐ **Type 1** ☐ **Type 2** ☐ **IGT/IFG** ☐ **Gestational**

SELF Monitoring Blood Glucose: Yes:☐ **No:** ☐

ATTACH RECENT BLOOD WORK – within past 3 months (i.e. HbA1C, Lipids, Glucose, eGFR, creatinine, etc.)

*******Referrals will not be accepted without supporting lab documents***.****

MEDICATIONS: *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.*

Other medications/conditions affecting diabetes:

Authorization for DEC Medical Directives

☐ Insulin Dose adjustments may be titrated by the Certified Diabetes Educator (CDE) according to current Medical Directive(s).

OTHER RELEVANT HEALTH PROBLEMS ☐ Coronary ☐ Dyslipidemia ☐ Exercise Restrictions
☐ High Risk Feet ☐ Hypertension ☐ Nephropathy ☐ Neuropathy ☐ Overweight
☐ Psychosocial ☐ Retinopathy ☐ Smoker ☐ Other_____

Date Received at DEC	**Family Physician:**	**Office use only:**
	Referring Health Care Professional:	