



**Huron Perth
Diabetes Education
Program**

Referral Form

Listowel Memorial Hospital

Phone: 519 291-3120 Ext. 6454

Fax: 519 291-1528

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		
<i>***NOTE: for insulin starts or changes – notify Diabetes Nurse Educator directly (ext.6234)***</i>		
Diagnosis: <input type="checkbox"/> New <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> IGT/IFG <input type="checkbox"/> Gestational		
SELF Monitoring Blood Glucose: Yes: <input type="checkbox"/> No: <input type="checkbox"/>		
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: <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"/> Coronary <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Exercise Restrictions <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 _____		
Date Received at DEC	Referring Health Care Professional:	Office use only:
	Referring HCP Fax and Phone Number:	