Referral to the Diabetes Education Program

3305 Harvester Road, Units 15-20, Burlington, Ontario, L7N 3N2
Fax #: 905-681-6341 Phone #: 905-632-8007 ext 107

*****Please refer patients who have Type 1 Diabetes, Gestational Diabetes, Pediatrics and those requiring pump therapy to an Endocrinologist*****

Time to turn over a new leaf
Diabetes Education Program on Harvester

Patient Name: _____ Health Card Number: _____

DOB (month/date/year): _____ Sex: ☐ Male ☐ Female

Home Address: _____ City: _____ Postal Code: _____

Primary Contact Number: _____ Alternate Contact Number/Email Address: _____

Type of Diabetes

☐Newly Diagnosed Type 2
☐Pre-existing Type 2 Diabetes (for__ years)
☐Pre-Diabetes

Reason for Referral

- ❑ URGENT 24-48 hours
- ❑ Diabetes Education ☐ Individual OR ☐ Group
- ❑ Diet Education Only
- ❑ Meter Teaching
- ❑ Insulin Start

Dr. Signature: _____(for insulin start/adjustment only)

- ❑ Insulin Type:_____
- ❑ Insulin Dose and Time: _____
- ❑ Certified Diabetes Educator (RN or RD) will teach patient insulin dose titration to their individual specific target

Medications:

Current Diabetes Medications	Other Medications

☐ **Copy of most recent Lab Report Included **(Please include most recent A1C and FBS (2 values) and most recent Lipids, Cr, ACR)****

Medical History:

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

Factors which may affect learning: i.e. language barrier, literacy concerns, visual impairment, mental health issues, financial concerns:
Please list:_____

Referring Doctor Name:_____ **Referring Doctor Signature:**_____

Date of Referral: _____ **Referring Doctor Fax #:** _____