REFERRAL FORM

FAX: 519-371-7695

□ Meaford □ Owen Sound □ Hanover □ Southampton □ Kincardine □ Markdale □ Wiarton

Name:
DOB: **HC #:**
Address:
Postal Code:
Phone (Home): **(Work):**
Physician(s):

TYPE OF DIABETES

□ Type 1 □ Pre Diabetes
□ Type 2 □ At Risk
□ Pregnant □ Steroid Induced
□ Gestational DM □ Other : _____

Date of Referral: _____
Date of Diagnosis: _____
Patient informed of referral? □ yes □ no
NOK or Contact Person:_____

MEDICAL AUTHORIZATION

(Protocols are located at www.gbhn.ca/ebc/current_initiatives.htm.)

☐ Initiate Insulin (please send a separate order with referral)
☐ Insulin Dose Adjustment Protocol
☐ HbA1C Ordering Protocol for Diabetes Educators
☐ Fasting Plasma Glucose/Lab Meter Comparison Ordering Protocol for Diabetes Educators
☐ Dispensing of Insulin and Diabetes Injectable Therapy Protocol by Diabetes Educators

Please check boxes to enact the protocols applicable to your patient and sign below.

Signature of Physician/Primary Care Provider: _____

RELEVANT MEDICAL HISTORY

□ Thyroid □ Sleep Apnea
□ Dyslipidemia □ Cancer
□ Retinopathy □ Coronary Artery Disease
□ Neuropathy □ Cerebro-vascular Disease
□ CKD □ Peripheral Vascular Disease
□ Hypertension □ Other: _____

PSYCHOSOCIAL FACTORS:

□ Depression □ Schizophrenia
□ Bipolar □ Addictions
□ Low literacy □ Smoker
□ Other: _____
Barriers to accessing service: _____
Barriers to learning: _____
Exercise restrictions: _____

MEDICATIONS:

Please attach Medication List if available.

LAB DATA

HbA1C		Date:
Glucose Fasting		Date:

Are Individualized Blood Glucose Targets Required?
If yes, HbA1C target is _____

ADDITIONAL COMMENTS:

RESPONSE TO REFERRAL: □ Urgent □ Routine

Triaged to □ RN □ RD □ Team □ NP Initials: _____
Calls placed: 1. _____ 2. _____ 3. _____
□ Appointment Date: _____ □No Response
□ Refused □Notification to Referral Source _____

Referred by: □ Physician □ Care Provider □ Self

Name: _____ **Contact Information:**_____

Revised April 2017