Diabetes Education Centre Referral Form

☐ **Belleville General T: 613 969 7400 x 2028 Fax: 613 961 2522**
☐ **Trenton Memorial T: 613 392 2540 x 2028 Fax: 613 961 5526**

For Timely access to care please complete in full. Incomplete forms will be returned to sender.

Date of referral: _____ Physician: _____
Last Name: _____ First Name: _____
Gender:_____ Preferred Language:_____
Date of Birth (YYYY/MM/DD): _____ Phone Number: _____
Health Insurance Number: _____VC: _____
Address: _____ Email Address: _____

Please note: We may not be able to accept new referrals for patients with A1C <7% deemed low risk at this time. Each referral is clinically reviewed in full by CDE and prioritized.

Pre-diabetes and/or <7.0% patients will be booked into a class. Please indicate if there are any barriers for your patient to receive group teaching:

Type of Diabetes: (Check one):

- ☐ Type 1 (A1C_____)
- ☐ Type 2 (A1C_____)
- ☐ Frequent hypoglycemia
- ☐ Recent DKA
- ☐ Pre-diabetes
- ☐ Other:

Present Diabetes Treatment:
(Check all that apply)

- ☐ Lifestyle Only
- ☐ Oral Antihyperglycemic (s)
- ☐ Injectable (non-Insulin)
- ☐ Insulin
  - ○ Basal
  - ○ Bolus
- ☐ Insulin Pump

Barriers to Self-Care:

- ☐ Cognitive impairment
- ☐ Financial
- ☐ Hearing
- ☐ Literacy
- ☐ Mental Health
- ☐ Physical Limitations

If Pregnant:

- ☐ Type 2 (A1C_____)
- ☐ GDM _____
- ☐ EDD: _____
- ☐ OGTT (Include Labs):_____

Medical History:

- ☐ CVD
- ☐ CKD
- ☐ Dyslipidemia
- ☐ Hypertension
- ☐ Neuropathy
- ☐ Obesity
- ☐ Retinopathy
- ☐ Sleep Apnea
- ☐ Smoking
- ☐ Thyroid Disease
- ☐ Other: _____

- ☐ Substance Misuse
- ☐ Visual impairment
- ☐ Other: _____

Additional Information: _____
_____
_____

Please provide a medication list and results of specific relevant lab results:
Fasting Blood Glucose, A1C, Lipids, Albumin Creatinine Ratio

_____

Initiating Insulin:
Prescribed Insulin, Dosage and Time:_____

☐ **I hereby authorize the Diabetes Educator to educate the client to adjust insulin 5 – 10% or 1-4 units of the total daily dose (per Quinte Health Medical Directive – Insulin Dose Adjustment Adults)**

☐ **I hereby decline teaching insulin adjustment**

Physician signature: _____ **Date**: _____