Scarborough Centre for Healthy Communities

Diabetes Referral Form

• Fax: 416-283-1057 • Phone: 416-847-4160

CLINIC USE ONLY 04/13

Date Received: _____

Appt. Date: _____

Copy sent to Physician: _____

REFERRAL LOCATIONS:

629 Markham Road, Unit 2
Scarborough, ON

The Hub-2660 Eglinton Ave E
Scarborough, ON

4002 Sheppard Ave E, Suite 401
Scarborough, ON

1333 Neilson Road, Suite 310
Scarborough, ON

PATIENT INFORMATION:

Name: _____

Address: _____

_____ Postal Code: _____

Daytime Phone Number: _____

Gender: ❑ Male ❑ Female Date of Birth: _____

REFERRAL SOURCE INFORMATION:

Address: _____

_____

Telephone Number: _____

Fax Number: _____

Patient informed of referral: ❑ Yes ❑ No

PREFERRED LANGUAGE: ❑ English ❑ French ❑ Hindi/Urdu ❑ Cantonese ❑ Tamil ❑ Mandarin ❑ Other: _____

DIAGNOSIS: ❑ Type 2 Diabetes ❑ Prediabetes ❑ # of months/years _____

REFERRED FOR: ❑ Diabetes Education ❑ Insulin Initiation ❑ GLP-1 Initiation ❑ Endocrinologist Consult ❑ Social Worker Consult
(CHECK ALL THAT APPLY)

MEDICAL HISTORY:

❑ Cardiovascular Disease
❑ Dyslipidemia
❑ Hypertension
❑ Renal Disease
❑ Retinopathy
❑ Neuropathy
❑ Foot/Wound Concerns
❑ Depression
❑ Obesity
❑ Other: _____

LABORATORY RESULTS: Date: _____

❑ Please attach lab reports if preferred

FPG:	CHOL:	TG:
OGTT:	LDL:	CREAT:
A1C:	HDL:	eGFR:

TREATMENT: ❑ Lifestyle management ❑ Medication ❑ Please attach medication list if preferred

Diabetes medications: _____

Other medications: _____

ORDERS FOR INSULIN INITIATION:

1) Insulin Type: _____

Dose and Time: _____

2) Insulin Type: _____

Dose and Time: _____

ORDERS FOR GLP-1 INITIATION:

GLP-1 Type: _____

Dose and Time: _____

MD SIGNATURE: (FOR ABOVE INSULIN/GLP-1 INITIATION)

_____

❑ MD to check box to approve insulin titration adjustment by RN/RD

ADVANCE DIRECTIVE (AD):

Certified Diabetes Educator may:

❑ Teach client insulin dose adjustment by 1-2 units or up to 10% of total daily insulin dose

❑ Decrease the oral diabetes medication in the event of hypoglycemia. Dose to be reduced by ½ - 1 tablet.

❑ Increase the oral diabetes medication in the event of hyperglycemia. Dose to be increased to double the dose or increased to the maximum recom-mended dose as per individual product monograph, whichever is less.

❑ Stop Metformin when CrCl/eGFR <30 ml/min or in the presence of hepatic failure (as per Diabetes Canada Clinical Practice Guidelines 2018).

* Caution if CrCl/eGFR <60 mL/min

MD SIGNATURE: (FOR ABOVE AD)

_____

Submit