

West Toronto Diabetes Education Program

185 Fifth Street Toronto ON M8V 2Z5
Phone 416-252-1928 • Fax 416-252-9141

Referral by: Dr. _____ Date: _____

Telephone: _____ Fax: _____

**** Please note: WTDEP mandate from the MOH is to see clients with Type 2 Diabetes.
We do not see clients with Type 1 or Gestational diabetes.**

Patient Name: _____ Phone: _____

Date of Birth: ____/____/____ Address: _____
Day / Month /Year

M F Postal Code: _____

Reason for Referral: Type 2 DM Pre-Diabetic High Risk

Language: English Other: _____ Interpreter needed? Yes No

LAB Values: Date: _____ Attached:

HBA1C ____ FBG ____ or Random ____ TC ____ HDL ____ LDL ____ TG ____ MicroAlb ____

Relevant Medical History: CVD Hypertension Dyslipidemia PCOS/Acanthosis nigricans
 Mental Illness Please specify: _____ Other: _____

Medications: _____

Concerns (specific issues for RD or RN to address or be aware of e.g. literacy, income, addictions, understanding of diabetes, stage of change, glycemic control):

Specialists involved: Endocrinologist: _____ Other: _____

Signature: _____

***You will receive a follow-up letter from the clinician after the patient has been seen. Please note the clinicians will be contacting you periodically for updated lab results.
You will find a list of our partners below.***

PLEASE MAKE COPIES AS REQUIRED

