West Toronto Diabetes Education Program
...achieving health goals together!

Ontario's Community Health Centres

United Way of Greater Toronto

For office Use:
Confirmed appt:

Diabetes Education Physician Referral Form
Type 2 Diabetes, Pre-Diabetes, or At Risk
Please fax form to: 416-252-9141

Date: _____

Patient Name: _____ **Phone:** _____

Date of Birth: (Day / Month /Year) _____/_____/_____ ☐ **M** ☐ **F** **Allergies:** _____

Address: _____

City: _____ **Postal Code:** _____

Referring Health Care Professional: _____

Phone: _____ **Fax:** _____

Reason for Referral: ☐ **Type 2 DM** ☐ **Pre-Diabetes/IFG/IGT** ☐ **High Risk**

Language: English ☐ **Other:** _____ **Interpreter needed?** ☐ **Yes** ☐ **No**

LAB Values: Date: _____ ☐ **See Attached**

HBA1C	FBG	Random	OGTT	TC	LDL	HDL	TC/HDL	Cr	eGFR	ACR

Relevant Medical History:

☐ **Family history** ☐ **Hypertension** ☐ **Dyslipidemia** ☐ **PCOS** ☐ **Acanthosis Nigricans**
☐ **Mental Illness** ☐ **Smoker** ☐ **Schizophrenia** ☐ **CHF** ☐ **Gestational Diabetes**
☐ **Retinopathy** ☐ **Neuropathy** ☐ **Nephropathy** ☐ **CVD** ☐ **Erectile Dysfunction**
☐ **MI** ☐ **Macrosomia** ☐ **Other**: _____

Oral medications and/or insulin: _____

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, barriers to access):

_____
_____
_____

PHYSICIAN'S ORDER for INSULIN INITIATION

☐ **Insulin Initiation: Type(s)** _____ **Dose & Time** _____
☐ **Diabetes Nurse Educator will teach patient insulin dose adjustment by 1-2 units or 10-20% of total daily dose**

Doctor Signature: _____