



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



WTDEP Registration form

Individual counseling with RN and RD Group Education Session

Name: _____ M F Date of Birth: ____/____/____
Day / Month / Year

Address: _____

Phone: (____) _____ When is the best time to reach you? _____

Primary Language: _____ Interpreter required: Y N

Email address (optional): _____

I allow WTDEP to contact me via email regarding program updates and upcoming events? Y N

Emergency Contact Name: _____ Phone: _____

Do you have any allergies? _____

What type of diabetes do you have? At risk Pre-diabetes Type 2 General Interest

How do you manage your diabetes? Diet/Exercise Oral Medication Insulin

How long have you had diabetes? _____

Previous diabetes education: Y N When: _____ Where: _____

Registration for Individual counseling with RN and RD

Do you have or experience any of the following (please check all that apply):

| | | |
|---|--|---|
| <input type="checkbox"/> Family history of diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Overweight/ Obesity | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Retinopathy (Eyes) | <input type="checkbox"/> Neuropathy (Nerves) | <input type="checkbox"/> Nephropathy (Kidney) |

Do you have a family doctor? Y N

If yes, Doctor Name: _____ Phone: _____

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