Ontario
South West Local Health Integration Network
Réseau local d'intégration des services de santé du Sud-Ouest

Fax: 519-657-4578
1-844-800-4758

REQUEST AND TREATMENT ORDER FORM

DIAGNOSIS : Type 1 Diabetes

Planned Start Date :

Client Name:_____
Contact Name:_____
Address:_____
Phone:_____
DOB:_____
HCN_____
School:_____

OHIP Billing K070

REASON FOR REFERRAL TO LHIN:

Child/teen requires school support over the **lunch hour** with:

☐ insulin administration
☐ blood glucose monitoring

Timing: _____

Child/teen and family to return to Children's Hospital for ongoing diabetes education and support.

If questions or concerns, please contact the appropriate diabetes team member at (519) **685 – 8500.**

CLIENT AWARE OF REFERRAL ? ☐ **Yes** ☐ **No**

Signature _____ Date _____

Paediatric Endocrinologist (519) 685-8500

☐ Dr. Clarson ext 52450
☐ Dr. Stein ext 58139
☐ Dr. Gallego ext 58139
☐ Dr. Sottosanti ext 58139

Physicians Signature _____
Date _____
Physician Signature for orders required under Regulated Health Professional Act.

Home Medication List

Family/RN/RPN is able to adjust insulin by 20% as per physician's order