

Centralized Diabetes Intake Referral Form

For Access to Diabetes Education Programs and the Centre for Complex Diabetes Care Phone: 1-888-997-9996 Fax: 1-905-444-2544 Toll Free Fax: 1-844-731-2161

Referral forms can be found at: http://healthcareathome.ca/centraleast/en

Patient Infor	mation				
Name:			Gender:		DOB (dd/mm/yy):
Address:					
Date patient informed of referral:			Health Card Number:		
Daytime Phone:			Alternate Phone:		
Primary language spoken:			_ Translation required: ☐ Yes ☐ No		
Primary Care Provider:			Primary Care Provider contact:		
Diabetes Specialist or Endocrinologist*			Diabetes Specialist contact:		
		nation and Reason for program, as well as urgency f		, please fill out as c	completely as possible)
Type of diabete	es: Type 1 new es	tablished Type 2 new	established	Pre-diabetes	If pregnant: Type 1 Type 2 GDM Due Date (dd/mm/yy):
Comorbidities:	☐ later stages of kidney disease or renal failure ☐ neurological conditions such as stroke, progressive neuropathy ☐ recurrent cardiac conditions such as congestive heart failure, myocardial infarct, angina				
	☐ retinopathy or vision threatened ☐ mental health/cognitive concerns				
	uncontrolled hypertension obesity				
Other Issues:	☐ recent repeated hospital admissions that may benefit from specialized out-patient follow-up ☐ recent repeated emergency room visits that may benefit from specialized out-patient follow-up				
	other barriers (e.g.:	financial, frail elderly, mobi	ility, etc.):		
Reason for referr	ral:				
☐ BG 15-20 mmol/L		☐ BG >20 mmol/L		\square A crisis that drastically affects the individual's ability	
☐ Recent treatment for DKA / HHS		☐ Severe hypoglycemia		to manage their diabetes	
☐ A1C 8.5 − 10%		☐ A1C > 10%		☐ Education	
☐ Insulin initiation / GLP1 initiation		☐ Change in Insulin reg	imen [☐ Recent discharge from hospital/ER related to diabetes	
☐ Pre-pregnancy counselling		☐ Insulin Pump therapy		☐ Inpatient, admitted related to diabetes Expected date of discharge:	
*Please note that	t if your patient requires	s a referral to an endocrinolo	ogist, referral	_	
Medication: Ple	ase attach current med	ications or list here:			
Relevant Med	dical History				
			months must	be attached . Cre	eatinine, lipid profile, ACR and any
Relevant Diagn Please attach rel	ostic Tests: evant test reports.				
Referred by:		Contact phone:	Fax:		
Signature:		Referral date (dd/mm/y	yy):		
CE-CDI-5 (06/24)					