HURON PERTH diabetes
Education / Support / Management

Huron Perth Diabetes Program Referral
South Huron Hospital Association, Exeter

Phone: 519 235-5175 Fax: 519 235-2945

NAME	**Referral Date**
ADDRESS	**Date of Diagnosis**
Phone # (h) _____ (cell) _____ (w)_____ **Phone Number can be reached at during day: _____**	**DOB** Day/month/year **OHIP Number**

REASON FOR REFERRAL – comments/special instructions

Diagnosis: ☐ **New** ☐ **Type 1** ☐ **Type 2** ☐ **IGT/IFG** ☐ **Gestational**

Currently does self-glucose monitoring ☐ **Yes** ☐ **No**

ATTACH RECENT BLOOD WORK – within past 3 months (i.e. HbA1C, Lipids, Glucose, etc.)

*****Referrals will not be accepted without supporting lab documents. *****

MEDICATIONS: *If referred for insulin start please clearly indicate prescribed initial insulin regimen and have patient fill prescription at the drug store and bring along to insulin start session.*

Other medications/conditions affecting diabetes:

Authorization for DEC Medical Directives

☐ Insulin Dose adjustments may be titrated by the Certified Diabetes Educator (CDE) according to current Medical Directive(s).

OTHER RELEVANT HEALTH PROBLEMS ☐ Coronary ☐ Dyslipidemia ☐ Exercise Restrictions
☐ High Risk Feet ☐ Hypertension ☐ Nephropathy ☐ Neuropathy ☐ Overweight
☐ Psychosocial ☐ Retinopathy ☐ Smoker ☐ Other_____

Family Physician:	**Office Use:** **Stamp Date received at DEC**	**Office use only:** **Triage:** **Recent A1C: _____%** □ **Urgent** □ **Team** □ **1-2 weeks** □ **RN only** □ **2-3 weeks** □ **RD only** □ **3-4 weeks** Previous patient: Yes □ No □ Last seen at DEC: _____
Referring Health Care Professional:		

Office use:
Date contacted: **Appointment Date & Time: _____**