DIABETES EDUCATION CENTRE
REFERRAL FORM

☐ **Rouge Valley Centenary-Adult**
2867 Ellesmere Road, Level 1
Scarborough, Ontario M1E 4B9
Tel: 416-281-7375
Fax: 416-281-7020

☐ **Rouge Valley Centenary-Pediatric**
2867 Ellesmere Road, Galaxy Clinic Level 12
Scarborough, Ontario M1E 4B9
Tel: 416-281-7371
Fax: 416-281-7313

NOTE: IT IS THE RESPONSIBILITY OF THE PATIENT TO CALL AND MAKE AN APPOINTMENT

LAST NAME:			FIRST NAME:		
DATE OF BIRTH -Y/M/D	SEX	HEALTH CARD #	HOME PHONE #	WORK PHONE #	CELL PHONE #
ADDRESS:					
CITY:		PROVINCE:		POSTAL CODE:	
REFERRING MD:		PHONE #		FAX #	
FAMILY MD:		PHONE #		FAX #	

REFER TO ENDOCRINOLOGIST:

☐ Dr. Farrukh Khan ☐ Dr. John Sigalas ☐ Dr. Margaret GanGaisano
☐ As required, for the Diabetes Education Centre Staff

MEDICAL DIRECTIVE:

☐ Certified Diabetes Educator will adjust insulin by 2-4 units or 10-20% of total daily dose
☐ Oral agents to be reduced or increased by CDE after review of renal and liver function
☐ Stop Metformin when Creatinine ≥ 150 or EGFR < 30mls/min

ORAL ANTI HYPERGLYCEMIC AGENTS :

1.The dose to be reduced by ½-1 tablet, if hypoglycemic (capillary blood glucose<4.0mmol/L) as per clinical practice guideline.
2.The dose to be increased to double the dose **OR** increase the dose to the maximum recommended dose as per individual product monograph, whichever is less, in the event of hyperglycemia as per the clinical practice guidelines.
3.For an increase in oral hypoglycemics, a physician is to be contacted unless both renal function (creatinine) and liver function (AST, bilirubin, ALP; 2 of the 3 tests must be available), and the lab results are within twice the upper limit.

☐ Type I (18 yrs & over)
☐ Type II (requiring insulin)
☐ Type II (diet/oral agents)
☐ Insulin initiation
☐ Pump therapy
☐ Gestational DM (_____ weeks)
☐ IGT in pregnancy (_____weeks)
☐ Planning pregnancy
☐ Impaired glucose tolerance/Impaired fasting glucose
☐ Type I Pediatric (under 18 yrs)
☐ Type II Pediatric (under 18 yrs)
☐ Pre Diabetic Pediatric

OTHER HEALTH PROBLEMS: _____

DURATION: ☐ New ☐ Established **PREVIOUS VISIT TO DEC:** ☐ Yes ☐ No
SPEAKS ENGLISH: ☐ Yes ☐ No **PREFERRED LANGUAGE:** _____

ANTI HYPERGLYCEMIC MEDICATIONS:

☐ Insulin: _____

☐ Oral Anti Hyperglycemic Agents : _____

PHYSICIANS ORDERS: _____

GESTATIONAL DIABETES / IMPAIRED GLUCOSE TOLERANCE IN PREGNANCY :

Date of lab work: _____ **2hr GTT:** FBS_____ 1hr_____ 2hr_____

RECENT LAB DATA

DATE	FBS	RBS	A1C	TC	HDL	TC/HDL RATIO	LDL	TG	CR	ALP	AST	ALB/CR RATIO

PHYSICIANS SIGNATURE AUTHORIZES THE USE OF THE MEDICAL DIRECTIVE
PHYSICIANS SIGNATURE: **DATE:**

OFFICE USE ONLY
Date referral received Date patient called Date patient booked

Form # 1430 Revised May 13, 2011