Peterborough Regional Health Centre

Diabetes Education Centre Referral Form

t: 705-876-5838 | f: 705-876-5156

PATIENT LABEL

Client's Name: ______________________ Sex: ☐ Male ☐ Female

Date Of Birth (DD/MM/YYYY): __________ Phone #: __________ Cell #: __________

Family Physician: __________ Referring Physician: __________

- **PLEASE ATTACH A LIST OF CURRENT MEDICATIONS THE PATIENT IS ON**
- **PLEASE ATTACH PATIENTS MOST RECENT LAB WORK**
  ***Lab work should include most recent HBA1C. Must be current within the last six (6) months.**

Please note: we may not be able to accept new referrals for patients with A1C <7% deemed low risk at this time.

Each referral is clinically reviewed in full by CDE and prioritized.

TYPE OF DM				
☐ Type 1	☐ Type 2	☐ Gestational (____ weeks)	☐ Newly diagnosed	☐ Established ____ years
☐ Other: ______				

PAST/PRESENT HEALTH PROBLEMS			
☐ Hypertension	☐ Nephropathy	☐ Retinopathy	☐ Neuropathy
☐ Dyslipidaemia	☐ Coronary Artery Disease	☐ Mental Health Diagnosis	
☐ Other: ______			

My signature authorizes the diabetes educator to educate the patient to adjust insulin by two (2) to four (4) units or 5-10% of that patient's total daily dose, as defined by the Canadian Diabetes Association Clinical Practice Guidelines for Diabetes Management in Canada.

☐ I decline teaching insulin adjustment

Based on Clinical Practice Guidelines for Management of Diabetes, clients may be referred to an Endocrinologist unless you decline.

☐ I decline referral

This referral has been discussed with the client: ☐ **Yes** ☐ **No**

Physician Signature: __________ **Date (DD/MM/YYYY):** __________

PRHC
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