north simcoe family health team

619 Prospect Blvd., Suite 3
Midland, ON L4R 0G3
Phone: 705-526-7804
Fax: 705-526-1205

Diabetes Education Program (DEP) Referral Form

Referral date:

Patient information:

Name: Sex: DOB (MM/DD/YYYY):
Address: City: Postal Code:
Phone: Cell:
Health Card Number: VC: Email:

Type of Diabetes: (check one)

□ Pre Diabetes □ Type 1 □ Type 2 □ Newly Diagnosed
□ Gestational/Pregnant with Diabetes

Duration of Diabetes: _____

Usual range of blood sugars: _____mmol/L to _____mmol/L

Treatment:

□ Diet/Lifestyle □ Oral □ Injectable □ Insulin □ Pump

Type of Service Requested:

□ Group Program □ Dietitian □ Nurse □ Insulin start (prescription attached)
□ Social Worker □ Diabetes Management Clinic (RN/RD)

Comment:

For patients being started on insulin or already on Insulin:

Will you allow the Diabetes Nurse Educator CDE to adjust insulin dosages? □ Yes □ No
(Medical directives in place)

Lab Results:

Please attach all recent blood work (A1C, LIPIDS, EGFR/ACR) □ Attached

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Referring Health Care Provider Information:

Provider Name: Phone: Fax:
Office Address: City: Postal Code:
Billing Number: Family Physician (if different):

Signature: Date:

Please fax the completed referral to our office at (705) 526-1205