HEADWATERS Health Care Centre

Diabetes Care Referral Form

Phone # 519-941-2410 ext 2525
Fax # 519-942-0482

Name: DOB (dd/mm/yyyy): Address: Contact #: HC#:	Referring Name: Address: Phone: Fax:

PRIORITY OF REFERRAL:

Urgent (seen within 2 business days)

- ☐ Newly Diagnosed Type 1
- ☐ Pregnant with pre-existing diabetes EDC_____
- ☐ Uncontrolled diabetes (blood sugars over 20, Ketonuria greater than 1.5mmol/L)
- ☐ Recent treatment for ketosis/nonketotic hyperosmolar hyperglycemia

Non-Urgent

- ☐ Type 1 of duration
- ☐ Type 2 newly diagnosed
- ☐ Type 2 of duration
- ☐ Pre-diabetes
- ☐ Steroid Induced
- ☐ In-Patient Follow Up
- ☐ At risk

- ☐ Gestational Diabetes (seen within 2 weeks) EDC_____

Duration in Years:	☐ Newly diagnosed	☐ 1 to 5 years	☐ 5 to 10 years	☐ 10+ years

Complications and Risks: (circle all that apply)

Hypertension	Dyslipidemia	PVC Foot ulcers	CVD	Neuropathy	Retinopathy	Other:
Cognitive Impairment	Depression	Smoker	Obesity	Mobility Impairment	CKD	

☐ Lab Results Attached

Date of Lab work dd/mm/yyyy	FBS	A1C	LDL	eGFR	ACR

OGTT	50g FBS 1 hr	75g FBS 1hr 2hr

Medications: Please provide (name/dose/frequency)

Signature Required for any of the following:

- ☐ Referral to Internal Medicine
- ☐ My signature authorizes the CDE to adjust insulin doses by 1 to 2 units or up to 20% as needed to achieve Diabetes Canada Clinical Practice Guidelines targets of 4 to 7 mmol/L ac meals and 5 to 10 mmol/L pc meals (only for physicians with privileges at Headwaters Health Care Centre).

Signature: _____ Billing #: _____