St. Thomas Elgin General Hospital
Delivering An Excellent Patient Care Experience

DIABETES EDUCATION PROGRAM REFERRAL

AFFIX PATIENT LABEL

Referral Date: _____ **Date of Diagnosis:** _____

Last Name: _____ **First Name:** _____

Address: _____ **Postal Code:** _____

Date of Birth: _____ **HC#** _____

Home Phone: _____ **Work/Cell Phone:** _____

Best Phone to reach patient: _____ **Patient Email Address:** _____

Family Physician: _____

Identify Need for Education:

- ☐ Pre-diabetes
- ☐ Gestational
- ☐ Diet counseling
- ☐ Inadequate glycemic control
- ☐ New onset diabetes - date of diagnosis: _____
- ☐ High risk based on: _____

A change in treatment regimen:

- ☐ No medication to oral agent
- ☐ From oral agent to insulin:
  - ☐ Name of insulin: _____
  - ☐ Starting Dose: _____

Physician Name:_____ **Physician Signature:** _____ **Date:** _____

Current Diabetes Medication:

- ☐ Diet
- ☐ Oral agent(s)
- ☐ Oral agent(s) + insulin
- ☐ Insulin
- ☐ Other: _____

Existing Barriers:

- ☐ Visual impairment
- ☐ Hearing impairment
- ☐ Language limitations
- ☐ Physical challenges
- ☐ Cognitive challenges
- ☐ Illiterate
- ☐ Other (please specify):_____

Existing Conditions:

- ☐ Exercise restricted
- ☐ Nephropathy
- ☐ Neuropathy
- ☐ Retinopathy
- ☐ Hypertension
- ☐ Cardiovascular Disease
- ☐ Peripheral Vascular Disease
- ☐ Thyroid dysfunction
- ☐ Dyslipidemia
- ☐ ETOH abuse
- ☐ Drug abuse
- ☐ Other (please specify): _____

Lab Values	Date	Result
Gluc Fast		mmol/L
HbA1c		%
Microalbumin		mg/day
EGFR		umol/L
Triglycerides		mg/mmol
Total Cholesterol		mmol/L
HDL		mmol/L
LDL		mmol/L
Cholesterol/HDL Ratio		mmol/L
HDL		mmol/L
LDL		mmol/L
Cholesterol/HDL Ratio		mmol/L
OGTT	**Date**	**Result**
Fasting		mmol/L
1 hour		mmol/L
2 hour		mmol/L
Blood Pressure		/ mmHg

Program Use Only:

- ☐ Class
- ☐ Individual RN _____
- ☐ Individual RD _____

Notification #1 _____
Notification #2 _____
Notification #3 _____