Diabetes Central Ottawa
Intake & Referral

Community-based Diabetes Education Programs in Ottawa – Referral Form

PLEASE FAX TO: 613-233-9487

Phone: 613-238-3722

(Children ≤ 17 years diagnosed with diabetes refer immediately to CHEO 613-737-7600 *0 and ask for diabetes physician on call)

Stamp:

CLIENT LAST NAME:_____

CLIENT FIRST NAME(S):_____

GENDER: ◯ M ◯ F ◯ Other: _____ **DOB**:_____/_____/_____
(YYYY) (MM) (DD)

◯ **ABORIGINAL** ◯ **CURRENTLY PREGNANT**

ADDRESS: _____
(#, Street, Apartment, City, Province, Postal Code)

TELEPHONE #: (_____)_____ **OTHER # (_____)_____**

CLIENT PREFERS SERVICES CLOSER TO ◯ Home **OR**

◯ Work/Other: _____

DIAGNOSIS: ◯ Prediabetes ◯ Type 2 Diabetes

DURATION OF DX: ◯ New Dx ◯1-5 yrs ◯ 5+ yrs

DIAGNOSIS: ◯ Type 1 Diabetes *
Is client seen by a diabetes specialist ◯ Y ◯ N

Name of specialist: _____
**Please note that the Community-based Diabetes Education Programs of Ottawa do not provide Group education or Insulin Initiation to clients with Type 1 Diabetes*

PREFERRED LANGUAGE OF SERVICE: ◯ English ◯ French ◯ Other:_____ ◯ **Interpreter required**

SERVICES REQUESTED / MAIN REASON FOR REFERRAL

◯ Diabetes Education and Support
Appropriate for Group? ◯ Y ◯ N _____

◯ Insulin Initiation ◯ Insulin and/or Medication Adjustment

Please attach labs and complete orders below.

MEDICAL HISTORY / RISK FACTORS ◯ Attached

RECENT LAB RESULTS ◯ Attached (*HbA1c, FBG, eGFR, ACR, Lipids)*

CHALLENGES THAT MAY IMPACT LEARNING OR SERVICES REQUESTED

◯ cognitive impairment ◯ developmental challenges
◯ non-insured ◯ no MD/NP
◯ mobility issues ◯ problematic drug/alcohol use
◯ homeless/marginal housing ◯ literacy
◯ mental health challenges: _____
◯ other: _____

CURRENT MEDICATIONS ◯ Attached (name/dose/frequency)

INSULIN INITIATION* Insulin type: _____ Dose / Time: _____
Titration Orders: Increase by _____ unit(s) at _____ (time) every _____ (night/day)
until _____ (am/pm/hs) readings are consistently under _____ (glycemic targets).
Discontinue AHA? ◯ N ◯ Y Specify: _____

INSULIN ADJUSTMENT*

Insulin type: _____ Dose: _____ Insulin type: _____ Dose: _____
◯ Diabetes Educator may teach insulin dose adjustment by 1-2 units/up to 10% daily insulin dose

GLP - 1 INITIATION / ADJUSTMENT

◯ Victoza ◯ Byetta
Dose: _____ Time:_____
Titration Orders:

***Physician Signature required for Insulin or GLP-1 Orders above:** _____

ADDITIONAL COMMENTS / SPECIAL INSTRUCTIONS

REFERRING PROVIDER (or Stamp)
Name:
Address:
Phone:
Fax: