diabetes GREY BRUCE
Education | Support | Treatment

DIABETES REFERRAL FORM

Fax: 519-378-1451

Incomplete referrals will be returned

Name:

DOB: **HC #:**

Address:

Postal Code: **Phone:**

Primary Care Provider:

Patient prefers to receive care in the following location:

☐ Owen Sound ☐ Markdale ☐ Meaford ☐ Wiarton ☐ Southampton ☐ Hanover ☐ Kincardine

DATE OF DIAGNOSIS: **Patient informed of referral?** ☐ Yes ☐ No

Contact Name/Number:

Patient Barriers:

TYPE OF DIABETES: ☐ Type 1 ☐ Type 2 ☐ Pregnant ☐ Gestational ☐ Pre-Diabetes ☐ At Risk

☐ Steroid Induced ☐ Other:

REASON FOR REFERRAL:

☐ New Diagnosis ☐ Pregnancy Planning ☐ Suboptimal Glycemic Control ☐ Insulin Start

☐ Sick Day Management ☐ Hypoglycemia ☐ Insulin Adjustment

☐ On or Starting Corticosteroid ☐ On or Starting Atypical Antipsychotic

☐ Symptomatic/Other:

RELEVENT MEDICAL HISTORY:

☐ Cancer ☐ CKD ☐ CAD ☐ Neuropathy ☐ Gastroparesis ☐ Thyroid

☐ Mental health ☐ PVD ☐ Retinopathy ☐ Sleep Apnea ☐ Stroke ☐ Hypertension

☐ Other:

MEDICAL AUTHORIZATION:

(Review protocols and select all that apply Referrals & Requisitions - Grey Bruce Health Services (gbhs.on.ca)*)*

☐ Initiate Insulin/GLP-1 **(complete order below)**

☐ Insulin Dose Adjustment Protocol

☐ HbA1C Ordering Protocol for Diabetes Educators

☐ Fasting Plasma Glucose/Lab Meter Comparison Ordering Protocol for Diabetes Educators

Signature of Prescriber:

ORDERS FOR SUBCUTANEOUS INSULIN / GLP-1

Insulin Type, Dose & Time:

Insulin Type, Dose & Time:

GLP-1 Type, Dose & Time:

Signature of Prescriber:

REQUIRED DOCUMENTATION:

☐ Medication list attached

☐ Current/relevant lab data attached (RBS, 2hr, OGTT, A1C, eGFR, Creatinine, T Chol/ HDL Ratio)

NOTES:

Referred by: **Date of Referral:**