

## Diabetes Program Referral - Adult

Please fax completed form to Central Access  
780.735-3553. For inquiries call 780.401.2665

\*Denotes Required Information

Please complete all patient demographic fields or affix Patient Label	
Name (Last, First)	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address	
City	Postal Code
Home phone	Alternate phone
Personal Health Number	Birthdate (yyyy-Mon-dd)

<b>*Referring Physician/Nurse Practitioner (required)</b>		<b>Family Physician (if different than Referring Physician)</b>	
Name	Practice ID#	Name	Practice ID#
Phone Number	Fax	Phone Number	Fax
<b>Diabetologist (if applicable)</b>		<b>Obstetrician/Gynecologist (if applicable)</b>	
Name	Phone	Name	Phone
<input type="checkbox"/> Primary Care Network (PCN)/Chronic Disease Management (CDM) Team			
Name of PCN		Phone Number	Fax Number
<b>*Adult Diabetes Referral Criteria (See Page 2 for Pre-Pregnancy/Gestational Diabetes)</b>			
*Diagnosis: <input type="checkbox"/> Pre-diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Other _____			
Date of Diagnosis: <input type="checkbox"/> less than 6 months <input type="checkbox"/> greater than or equal to 6 months			
Labwork – Current within 3 months? <input type="checkbox"/> Yes			
Require at least one of the following: A1C (preferred) or Fasting Glucose or Random Glucose			
Most Recent Blood Pressure _____ / _____ mmHg.			
Previous Diabetes Education <input type="checkbox"/> Yes <input type="checkbox"/> No		Current Treatment <input type="checkbox"/> Diet and Activity <input type="checkbox"/> Insulin <input type="checkbox"/> Diabetes Medication <input type="checkbox"/> Insulin Pump	
Recent Hypoglycemic Episodes? <input type="checkbox"/> No <input type="checkbox"/> Yes		Insulin Pump Education Requested? <input type="checkbox"/> Yes	
If yes did it require emergency room service? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Last seen in hospital for diabetes: Date (yyyy-Mon-dd) _____			
<b>Other Medical Information/Diabetes Concerns (i.e. current steroid treatment, pancreatectomy, pancreatitis)</b>			

Please complete Special Considerations on Page 2

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### Pre-Pregnancy/Pregnancy/Gestational Diabetes

Gestational Referrals Require: GDS and/or Oral Glucose Tolerance Test (OGTT)

Weeks Gestation	Estimated Date of Confinement (EDC) <i>(yyyy-Mon-dd)</i>	Gravida	Para
Diagnosis <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Gestational	Previous GDM <input type="checkbox"/> Yes <input type="checkbox"/> No		
Anticipated Delivery Site: <input type="checkbox"/> Royal Alexandra <input type="checkbox"/> Grey Nuns <input type="checkbox"/> Misericordia <input type="checkbox"/> Sturgeon			
Pre-Pregnancy Planning <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2			
Blood Pressure _____ / _____ mmHg			
Special Circumstances _____			

### Special Considerations

<input type="checkbox"/> Does the person speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No
If <b>no</b> , Please specify alternate language _____
Name of English speaking contact person _____ Phone _____
<input type="checkbox"/> Cognitive impairment
<input type="checkbox"/> Hearing, visual impairment, requires oxygen, etc. <i>Please specify</i> _____
<input type="checkbox"/> Activity limitations e.g. walker, cane, etc. <i>Please specify</i> _____