Diabetes Central Ottawa
Intake & Referral

Community Diabetes Education Programs of Ottawa – Referral Form

PLEASE FAX TO 613-233-9487 (Toll-free: 1-833-533-9487)

TEL: 613-238-3722 (Toll-free: 1-833-338-3722) www.diabetesottawa.ca

(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)

◯ **INDIGENOUS** ◯ **CURRENTLY PREGNANT**

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

TELEPHONE #: (   ) ____________ **OTHER #: (   )** ____________ Alternate Contact person: ____________

CLIENT PREFERS SERVICES CLOSER TO ◯ Home **OR** ◯ Work/Other (*provide location*): ____________

DIAGNOSIS: ◯ **Prediabetes** **or** ◯ **Type 2 Diabetes**

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

PREFERRED LANGUAGE OF SERVICE:
◯ English ◯ French ◯ ***Other**:____________ (**specify language*)
◯ **Interpreter required** (*check box*)

***Please note:** The Community Diabetes Education Programs of Ottawa do not provide group education or insulin initiation to clients with Type 1 Diabetes.*

◯ **Type 1 Diabetes**

Question for Type 1 Diabetes: Is client seen by a diabetes specialist? ◯ Y ◯ N

If yes, please provide name of specialist: ____________

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.

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:____________

MEDICAL HISTORY / RISK FACTORS ◯ Attached

CURRENT MEDICATIONS ◯ Attached (name/dose/frequency)

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

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 Oral Medication(s)? ◯ N ◯ Y (Specify): ____________

INSULIN ADJUSTMENT* *(Must be completed to allow educator to teach insulin dose adjustment)*

Insulin type:____________ Dose: __________ Insulin type:____________ Dose: __________

GLP - 1 INITIATION / ADJUSTMENT*

Type: ____________

Dose:__________ Time:__________

Titration Orders:

◯ **Check box** to allow **Diabetes Educator to teach insulin dose adjustment by 1-2 units/up to 10% daily insulin dose**

***Physician / NP Signature required for Insulin or GLP-1 Orders above:**____________

(PLEASE SIGN HERE↑)

ADDITIONAL COMMENTS / SPECIAL INSTRUCTIONS

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