

Champlain Diabetes Chiropody Program - Referral Form

Please Fax *Completed* Referral to **613-774-7241**

Tel: **613-783-7760** Toll free: **1-888-220-8010**

Please note: Admission to services is not guaranteed

All incomplete forms will be returned to the referring provider. All fields are mandatory.



Referring Provider: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Fax Number :(\_\_\_\_) \_\_\_\_\_ Request communication back?  Yes  No

**Client Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

DOB: (YYYY)/(MM)/(DD) \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  M  F  Other: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Alternate Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

OHIP# \_\_\_\_\_ V.C. \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

Language:  English  French  Other: \_\_\_\_\_ Client HbA1C: \_\_\_\_\_

Client has:  Type 1 Diabetes  Type 2 Diabetes (Insulin, Oral and/or Diet)  Pre Diabetes

**\*IMPORTANT\* Current Allergies, Imaging/Lab results, Medical History and Medications are required to access services. Incomplete referrals will be returned to referring provider.**

\* History of present illness: Attached  \_\_\_\_\_

\* Allergies: Attached  \_\_\_\_\_

\* Medications: Attached  \_\_\_\_\_

\* Imaging/Lab results: Attached  \_\_\_\_\_

**Referral for:**

Foot ulcer:

Please also refer to Home & Community Care for nursing care

If you are a Physician/NP: Check box to allow Chiropodist to request Vascular and/or Infectious disease consult as needed

Physician/N.P Signature: \_\_\_\_\_ OHIP Billing# \_\_\_\_\_

*Both Signature and OHIP Billing Number is required for the consult above*

Ingrown toenail with bacterial infection (Please start antibiotics if infection present)

**Additional Comments:**

Specify ulcer location(s) →



**We do not provide routine foot care. Our clinics provide services for diabetic foot ulcers and ingrown toenails with bacterial (not fungal) infections**