Diabetes Central Ottawa
Intake & Referral

Community Diabetes Education Programs of Ottawa – Referral Form

PLEASE FAX TO 613-774-7235 (Toll-free: 1-833-384-9993)

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)

CLIENT LAST NAME: _____

CLIENT FIRST NAME(S): _____

Stamp:

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.

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 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: