ST. JOSEPH'S CARE GROUP
DIABETES HEALTH

Diabetes Health Self Referral

63 Carrie St. Thunder Bay, ON P7A 5J7 Phone: 807-344-3422 Fax: 807-346-8006

Client Name:	Date of Birth: YYYY / MM / DD
Address:	Health Card:
Pharmacy:	Phone:
Family Physician/NP:	Specialist(s):
Type of Diabetes: □ Prediabetes □ Type 1 □ Type 2 □Pregnancy □ Pump	
New Diagnosis: □ Yes □ No	Date of Diagnosis:
Have you had diabetes education in the past? □ Yes □ No	
Please list your current diabetes medications:	
Do you wear a glucose sensor? □ Yes □ No	
We require a recent A1C level and/or current glucose levels to review your referral:	
Recent A1C level or date of last bloodwork:	Current blood sugar trends or concerns:
Have you been hospitalized in the last year? □ Yes □ No	
Please provide a reason for the referral:	

□ I authorize Diabetes Health to contact my primary care practitioner, pharmacy and obtain my most recent lab work.

Client Signature: _____ Date: _____