# DIABETES HEALTH OUT-PATIENT REFERRAL FORM

ST. JOSEPH'S CARE GROUP

St. Joseph's Heritage
63 Carrie Street
Thunder Bay, ON P7A 4J2
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1 800-489-3422 Fax: (807) 346-8006

Name: _____ _____
Last First

Address: _____

_____
City/Town Postal Code

Phone: _____ Allergies: _____

D.O.B: _____ Health Card #: _____

Parent/Guardian: _____

Require Interpreter: Yes ☐ No ☐

Date of Diagnosis: _____ Has RX for Testing Supplies: Yes ☐ No ☐
(Month/Year)

## TYPE OF DIABETES

- ☐ Type 1
- ☐ Type 2
- ☐ Pregnant Type 1 or 2
- ☐ Gestational
- ☐ Impaired Fasting Glucose
- ☐ Impaired Glucose Tolerance
- ☐ High Risk
- ☐ Other

## MEDICAL HISTORY

**OUTPATIENT–** Reason for Referral

- ☐ New diagnosis – self management Education
- ☐ Pre-existing/Reassessment
- ☐ Insulin Start (Orders Required)
- ☐ Other

**CURRENT MANAGEMENT**

- ☐ Diet / Exercise
- ☐ Oral Medication
- ☐ Injectable Incretin
- ☐ Basal Insulin
- ☐ Bolus Insulin
- ☐ Insulin Pump
- ☐ Other

**LAB:** Include A1C, ACR,LDL-C, eGFR

- ☐ Attached
- ☐ Ordered/Pending

**MEDICATION LIST**

- ☐ Attached

Pharmacy: _____

**IN-PATIENT…** Place referral in Meditech

**EXERCISE** ☐ AAT ☐ Restrictions(specify)

**COMMENTS/CONCERNS** (barriers, cognition, financial, situational, motivation, mobility)

**HEALTH PROFESSIONAL** Stamp or printed name

_____
Signature

**Diabetes Health use only**

**** INCOMPLETE OR ILLEGIBLE FORM WILL BE RETURNED ****