STEVENSON MEMORIAL HOSPITAL

200 Fletcher Crescent
Alliston, Ontario L9R 1W7
Tel: 705-435-6281

DIABETES EDUCATION CENTRE (DEC)

DIABETES EDUCATION PROGRAM (DEP) REFERRAL FORM

Patient's Name:	Allergies: ☐ NKA	
Language preferred, if not English:	Primary Phone:	Secondary Phone:

Reason for Referral:
- ☐ Diabetes Education
- ☐ Insulin/GLP- Analog Start (write order/attach Rx and sign below)
- ☐ Inpatient/ER follow-up
- ☐ Pre-pregnancy planning - ☐ Type 1 ☐ Type 2
- ☐ OTN Diabetes Education consult
- ☐ _____

Type of Diabetes:
- ☐ At risk
- ☐ Pre-diabetes ☐ newly diagnosed OR year diagnosed: _____
- ☐ Type 2 - ☐ newly diagnosed OR year diagnosed: _____
- ☐ Type 1 - ☐ newly diagnosed OR year diagnosed: _____
- ☐ Pregnant with gestational diabetes _____ weeks
- ☐ Pregnant with ☐ Type 1 ☐ Type 2 _____ weeks

Insulin or GLP-1 Analog Order:	Dose:	Time:

☐ Continue current diabetes oral medication ☐ Stop these after insulin/GLP-1 Analog start:

Current Medications:	Dose	Route	Freq.	Current Medications:	Dose	Route	Freq.

Additional Considerations:
☐ Hypertension ☐ Dyslipidemia ☐ Cardiovascular disease ☐ Foot ulcer ☐ Nephropathy ☐ Neuropathy ☐ Retinopathy
☐ Other: _____

Laboratory Results: Please attach all recent blood work (including HbA1C, lipid profile, FPG, OGTT, etc.) ☐ Attached

Referring Health Care Provider Information:
A report of the visit will be provided to:

Name: _____

Address: _____

Phone: _____ Fax: _____

Billing Number: _____

Physician Orders:

1. I authorize the Diabetes Educator(s) to adjust this patient's insulin based on the DEP's Medical Directive (available from the DEP. The Diabetes Educator will provide education on how to self-titrate insulin based on the blood glucose, carbohydrate intake and physical activity. ☐ Yes ☐ No

2. I authorize an Endocrinologist to see this patient on an urgent basis IF AVAILABLE ON SITE. ☐ Yes ☐ No

MD Name:	Discharge Time:
Signature:	Date: