NORTH YORK GENERAL
Making a World of Difference

Centre for Complex Diabetes Care (CCDC) REFERRAL FORM

FORM SF0279 **Page 1 of 1** **Rev. 05/2020**

Patient LABEL / Identification Area

Centre for Complex Diabetes Care (CCDC): NYGH Outpatient & Community Services Centre
Unit E7, 2 Champagne Drive, Toronto, ON M3J 0K2 Tel: 416-756-6924

PLEASE FAX YOUR REFERRAL TO CCDC
Fax: 416-756-6329

The CCDC inter-professional team consists of endocrinologists, nurse practitioners, registered nurses, registered dietitians, social workers, a pharmacist and a chiropodist. CCDC is a short stay program; all patients are assigned a case manager to coordinate their care and include their circle of care as needed. Care is focused on patients' specific goals and diabetes needs. Patients are transitioned to a Diabetes Education Centre when appropriate.

PATIENT INFORMATION

Name:	DOB:	Home #
Address:	GENDER: ☐ Male ☐ Female	Cell #
	Prefer to self describe as _____	Work #
Spoken language: ☐ Interpreter Required	HCN:	Email:

DIAGNOSIS

☐ Type 1 Diabetes for _____ years ☐ Type 2 Diabetes for _____ years ☐ Other_____

REASON FOR REFERRAL (Please check at least 1 box or provide details below)

Patients who do not meet the referral criteria will automatically be referred to the NYGH Diabetes Education Centre (DEC)

☐ Sub-optimal glycemic control
☐ Unmanaged diabetes complications
☐ Barriers in accessing health care
e.g. serious mental illness/mobility/frail elderly
☐ Chiropody services:
e.g. high risk requiring preventative footcare, wound care
☐ Recurrent hospitalization/ER visit
☐ Comorbidities which impact glycemic control

Off-site Services (referral to be triaged for appropriateness)
☐ OTN/ MS Teams Consult
☐ Off-site foot care
☐ Social Work

Please provide details or specific concerns to be addressed:
☐ Attach consult note and/or:

_____

_____

RELEVANT MEDICAL HISTORY

Medication: ☐ Attach list or ☐ List here:

_____

_____

Laboratory Tests: ☐ Attach most results (e.g. A1C; incomplete data will result in delayed booking)

☐ **Allow for Endocrinology consult at CCDC's discretion**. Billing Number_____

* Your signature below authorizes Nurses (RN), dietitians (RD) and pharmacist to adjust insulin and perform capillary blood ketone tests as per NYGH approved Medical Directives. Comments:

REFERRING HCP/ PHYSICIAN INFORMATION (or stamp)	PRIMARY CARE HCP/ PHYSICIAN INFORMATION
Name:	☐ same as referring physician or Name _____
Address:	Address: Phone:
Phone:	Phone:
Fax: Email:	Fax:

REFERRING SIGNATURE	PRINT NAME	DATE

Approved By: CCDC Forms Committee; Approval Date: 05/2020 (archive: N/A)