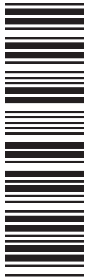

NORTH YORK GENERAL
Making a World of Difference

Diabetes Education Care (DEC) REFERRAL FORM

FORM PS307 Rev. 05/2020

Patient LABEL / Identification Area

UNIT E7, 2 CHAMPAGNE DRIVE, TORONTO, ON, M3J 0K2 TEL:416-756-6923 FAX: 416-756-6329

Patient name: ______________________________

Height: __________ Telephone #: Home______________Work______________Cell______________

Weight: __________ Email Address: ______________________________

REASON FOR REFERRAL: (The patient will be seen by a multidisciplinary team)

☐ Newly Diagnosed ☐ BG Control ☐ Insulin Administration ☐ Diet
☐ Hypoglycemia ☐ Self BG Monitoring ☐ Therapy Adjustment ☐ Start MDI

HISTORY

Diabetes Type: ☐ 1 ☐ 2 ☐ Gestational ☐ IFG ☐ IGT Date of diagnosis:______________

☐ Coronary Artery Disease ☐ Neuropathy ☐ Hypertension ☐ Obesity
☐ Peripheral Vascular Disease ☐ Retinopathy ☐ Dyslipidemia ☐ Symptomatic
☐ Cerebral Vascular Disease ☐ Nephropathy ☐ Foot/Skin Problems ☐ Erectile Dysfunction
☐ Other

SIGNIFICANT MEDICAL HISTORY:

LAB DATA/ ☐ attached

Date	FBG	RBG	HbA1C	CHOL	HDL	LDL	TRIG	ALT	Creatinine	Microalbumin/ Creatinine ratio

GESTATIONAL GTT_______gm FBG_______ 1hr _______ 2hr ________ EDC______________

MEDICATIONS

☐ Current ☐ To be initiated

Diabetes:

Other:

DIET

Restrictions:

☐ Low Cholesterol ☐ Low Sodium ☐ Low Protein ☐ Alcohol ☐ Others ___________

Your signature authorizes the dietitian to alter meal plan as required and the nurse to administer and adjust diabetes medication according to the medical directive approved by North York General Hospital.
Summary/ Progress Reports will be sent. Patients are expected to return to their family physician.

____
Referring Physician Signature

Date:

Name, mailing address,
telephone & fax:
(please print or stamp clearly)
Send additional reports to:

DATE	TIME (24 h)	SIGNATURE	PRINT NAME