diabetes GREY BRUCE
Education | Support | Treatment

REFERRAL FORM

FAX: 519-371-7695

□ Meaford □ Owen Sound □ Hanover □ Southampton □ Kincardine □ Markdale □ Wiarton

Name:
DOB: **HC #:**
Address:
Postal Code:
Phone (Home): **(Work):**
Physician(s):

TYPE OF DIABETES

□ Type 1 □ Pre Diabetes
□ Type 2 □ At Risk
□ Pregnant □ Steroid Induced
□ Gestational DM □ Other : ____________

Date of Referral: _________________________
Date of Diagnosis: ____________________________
Patient informed of referral? □ yes □ no
NOK or Contact Person:___________________________

MEDICAL AUTHORIZATION

(Protocols are located at www.gbhn.ca/ebc/current_initiatives.htm.)

☐ Initiate Insulin (please send a separate order with referral)
☐ Insulin Dose Adjustment Protocol
☐ HbA1C Ordering Protocol for Diabetes Educators
☐ Fasting Plasma Glucose/Lab Meter Comparison Ordering Protocol for Diabetes Educators
☐ Dispensing of Insulin and Diabetes Injectable Therapy Protocol by Diabetes Educators

Please check boxes to enact the protocols applicable to your patient and sign below.

Signature of Physician/Primary Care Provider: ____

RELEVANT MEDICAL HISTORY

□ Thyroid □ Sleep Apnea
□ Dyslipidemia □ Cancer
□ Retinopathy □ Coronary Artery Disease
□ Neuropathy □ Cerebro-vascular Disease
□ CKD □ Peripheral Vascular Disease
□ Hypertension □ Other: ____________________

PSYCHOSOCIAL FACTORS:

□ Depression □ Schizophrenia
□ Bipolar □ Addictions
□ Low literacy □ Smoker
□ Other: _____________________________
Barriers to accessing service: ____________________
Barriers to learning: ___________________________
Exercise restrictions: ___________________________

MEDICATIONS:

Please attach Medication List if available.

LAB DATA

HbA1C		Date:
Glucose Fasting		Date:

Are Individualized Blood Glucose Targets Required?
If yes, HbA1C target is ________________

ADDITIONAL COMMENTS:

RESPONSE TO REFERRAL: □ Urgent □ Routine

Triaged to □ RN □ RD □ Team □ NP Initials: _____
Calls placed: 1. ________ 2. __________ 3. __________
□ Appointment Date: ____________ □No Response
□ Refused □Notification to Referral Source ________

Referred by: □ **Physician** □ **Care Provider** □ **Self**

Name: ____ **Contact Information:**______________________________

Revised April 2017

HDH HANOVER & DISTRICT HOSPITAL

GREY BRUCE Health SERVICES

S.B.G. HEALTH CENTRE