PRINCE EDWARD FAMILY HEALTH TEAM
A team approach to your good health

DIABETES EDUCATION PROGRAM
REFERRAL FORM

Date of Referral:

Name:

Address:

Home Phone:

Date of Birth: **Sex:** **Family Physician:**

Referred by:
Urgency of Referral:

Type of Diabetes:

__ Type 1 __ Type 2 __ Prediabetes

Duration of Diabetes:

Reason For Referral

__ New Diagnosis
__ Insulin Initiation
__ Other, specify:
__ Frequent Hypoglycemia
__ Diabetes out of control

Please attach current medication list
Please attach results of specific relevant lab tests;
Fasting Blood Glucose, A1C, Lipids, Albumin Creatinine Ratio

Barriers to Learning/Education

__ Language barrier __ Visual deficit
__ Literacy __ Hearing deficit

Other Health Concerns:

Insulin- SEE PAGE 2

If this referral is for Insulin Initiation, please fill out the following.

Part A:

__ All Anti Hyperglycemic Agents are to be stopped 24 hours before starting insulin.

OR

__ Anti Hyperglycemic Agent(s) to be continued as follows:

Prescribed Insulin, Dosage and Time:

Specify blood glucose target, if other than guidelines:

Part B:

PEFHT #MDD01Medical Directive **Insulin Dose Adjustment** approved February 2009 allows the Diabetes Educator certified in Insulin Dose Adjustment to make appropriate changes to insulin doses.

Fax Completed Referral Form to Prince Edward Family Health Team
Attention: Suzanne Staley
1-866-476-0425