

Niagara Medical Group Family Health Team Diabetes Program (Adult Type 2 - Non Pregnant) Referral Form

Referring Primary HCP _____ Telephone Number _____ Fax Number _____ Family Physician _____	Fax to: (905) 356-2765 Niagara Medical Group Family Health Team 4421 Queen St. Niagara Falls L2E 2L2 (905) 356-2236 ext 274
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Patient _____
First Name Last Name

DOB (dd/mm/yyyy) _____ **Age** _____

Health Card _____
Version code

Phone (Home) _____
(Other) _____

Alternate Contact Person _____

Address _____

**Medication List
(or attach list of meds)**

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

**Factors which may
affect learning**

- Language
 - Preferred: _____
- Interpreter required
- Visual impairment
- Auditory impairment
- Cognitive impairment
- Physical disability
- Mental health
- Low literacy
- Social situation
- Financial situation
- Other _____
- _____

Reason for Referral

- Assessment and Education/Management
- Insulin Initiation: Type/dose and titration order required
- Other-please specify

Diagnosis

- Type 1: date diagnosed/years _____
- Type 2: date diagnosed/years _____
- Medication Induced _____
- Other _____

**Lab data within the last 3 months
(Please complete or attach results)**

	Results	Date
FBG	_____	_____
A1C	_____	_____
ACR	_____	_____
Creatinine	_____	_____
eGFR	_____	_____
Chol.	_____	_____
LDL	_____	_____
HDL	_____	_____
Trig	_____	_____
Chol/HDLratio	_____	_____
Albumin	_____	_____

Recent Medical History

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> New Type 1 <input type="checkbox"/> Hypertension <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Obesity <input type="checkbox"/> Celiac <input type="checkbox"/> Erectile dvsfunction <input type="checkbox"/> Hyperosmolar hyperglycemia <input type="checkbox"/> Hospitalization/ED Date _____ <input type="checkbox"/> Retinopathy <input type="checkbox"/> Other _____ | <ul style="list-style-type: none"> <input type="checkbox"/> Neuropathy <input type="checkbox"/> Nephropathy <input type="checkbox"/> Skin Infection or wound <input type="checkbox"/> Severe hypo < 2.5 mm/l <input type="checkbox"/> MI or ACS Date: _____ <input type="checkbox"/> Diabetic Ketoacidosis |
|--|---|

Physician/Primary Health Care Provider Signature _____ **Date** _____

Appointment date/time: _____ **Patient to bring glucometer/log book to appointment**