north simcoe
family health team

Community Diabetes Education Program (DEP) Referral Form

Date of Referral: _____

Name: _____ Date of Birth: _____

Address: _____ Phone:(H) (W) _____

Town: _____ Postal Code: _____

Health Card Number/ VC: _____ Allergies: _____

Physician _____

Type of Diabetes (check one)

☐ Type 1 ☐ Type 2 Duration of Diabetes: _____
☐ Pre Diabetes Usual range of blood sugars: _____mmol/L to _____mmol/L
☐ Gestational / Pregnancy with Diabetes

Type of Service Requested:

☐ Group Program ☐ Dietitian 1:1 ☐ Nurse 1:1 ☐ Social Worker ☐ Foot Care (as per criteria)

☐ Insulin start ☐ Diabetes Management Clinic (RN/RD)

☐ ***New*** Shared Care NP Diabetes Clinic (for new clients/those not meeting targets)

Comments: _____

_____

For patients being started on insulin or already on Insulin: Will you allow the Diabetes Nurse Educator CDE to adjust insulin dosages? (medical directives in place)

☐ Yes ☐ No

PRIMARY HEALTH CARE PROVIDER SIGNATURE: _____

PLEASE ATTACH RECENT LABS (A1C, LIPIDS, EGFR/ACR)

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