Date:_____

HHCC Diabetes Care Program Referral

Headwaters Health Care Centre
100 Rolling Hills Drive
Orangeville, Ontario L9W 4X9
Phone:519-941-2410 ext.2525
Fax: 519-942-0482
(Patient will be seen by RN & RD)

Family MD: _____

Referring MD:_____

Name:_____

Address:_____

_____

Sex: M F DOB(D/M/Y)_____

Phone: Home_____Work_____

Health Card :_____

Priority:

Non-Urgent (seen within 2 weeks)

- ❑ Newly Diagnosed Type 2
- ❑ Type 2 of duration
- ❑ Type 1 of duration
- ❑ Pre-diabetes
- ❑ Insulin Pump Training
- ❑ Gestational Diabetes
  EDC_____ # weeks gestation _____
- ❑ Inpatient Follow Up
- ❑ Type 2 Insulin Initiation

Urgent (seen within 2 Business Days)

- ❑ Newly Diagnosed Type 1
- ❑ Pregnant with pre-existing diabetes
  EDC_____ # weeks gestation _____
- ❑ Uncontrolled and symptomatic with blood sugars above 20
- ❑ Recent crisis in management i.e. DKA, hypoglycemia, hyperglycemia requiring Rx

Medical History:

- Coronary Artery Disease
- Peripheral Artery Disease
- Hypertension
- Thyroid Disease
- Hyperlipidemia
- Neuropathy
- Nephropathy
- Retinopathy
- Foot/Skin Problems
- Smoker
- Substance Abuse

S/B Opthamologist N Y Date:
Other Medical Conditions:

Previous Diabetes Education N Y
When? Where?

Laboratory Results: (see attached Y N)

Date:_____/ FBS_____ RBS _____ 2hr pc_____ HgbA1c_____
Date: _____/ Cholesterol_____ Triglycerides_____HDL_____ LDL_____
Date: _____/TSH_____ Microalbumin_____ A/C ratio_____
Date: _____/(Gestational) 50 gm 1hr_____ 75 GTT FBS_____ 1hr_____ 2hr_____

Medications:

Insulin/Oral Agents:

Other Medications:

Initiate Insulin Therapy: Y N

Treatment/ Orders:

My signature authorizes the CDE to initiate and/ or adjust insulin, diabetes medications and blood glucose monitoring, as well as order laboratory blood glucose, HgbA1c, lipids, microalbuminuria screen and the Dietitian to prescribe appropriate medical nutrition therapy.

Date:_____ Sig. :_____

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