WILLIAM OSLER HEALTH SYSTEM

Centre for Complex Diabetes Care (CCDC)
REFERRAL FORM

302-2250 Bovaird Drive East
BRAMPTON ON L6R 0W3
TEL: 905-494-2260 | FAX: 905-595-2863

DATE OF REFERRAL : _____/_____/_____ (dd/mm/yy) LOCATION: ☐ Brampton Civic Hospital ☐ Etobicoke General

CCDC INFORMATION

The CCDC interdisciplinary team offers collaborative, case management based care to improve the health status and quality of life for persons with difficult to manage diabetes.
Care is concurrent along with the Primary Care Provider (PCP)

The CCDC will: Notify the PCP/referring MD about appointment within one week of the referral
Provide a patient summary note after each clinic visit
Discharge patients back to PCP when identified concerns are stable with a recommendation summary
Please note that patients who do not meet the referral criteria will automatically be referred to the Diabetes Education Program.

PATIENT INFORMATION

Last Name_____ First Name_____ Gender: M ☐ F ☐

Health Card No._____ Date of Birth _____/_____/_____ (dd/mm/yy)

Address _____ City _____

Postal Code _____Phone (_____)_____ Alternate Phone (_____)_____

Language if unable to speak English:_____

REFERRING PHYSICIAN INFORMATION

Name_____ Specialty_____

Address _____ City _____

Phone (_____)_____ Fax (_____)_____ E-mail _____

OHIP Billing No. _____ **Referring Physician's Signature**_____

Family Physician Information (if different):
Name_____ Phone: (_____)_____

DIAGNOSIS

☐ Type 1 Diabetes for ____ years ☐ Type 2 Diabetes for ____ years

REASON FOR REFERRAL

Poor glycemic control (e.g. A1C over 9%, severe hypoglycemia or other) ***AND*** two or more of the following:

☐ Cardiovascular disease ☐ Peripheral arterial disease ☐ Retinopathy/Low vision/Blindness ☐ Neuropathy
☐ Recurrent diabetes related emergencies/hospital admissions ☐ Mental Health/Cognitive Concerns ☐ Nephropathy
☐ Medical conditions that impact on management (e.g. COPD, Malignancy or other)
☐ Other barriers that challenge self management (e.g. financial, difficulty accessing care)

RELEVANT MEDICAL HISTORY

Please attach: ☐ Lab results within the last 3 months (FBS, A1C, Lipid profile, creatinine, ACR, transaminases, CK)
☐ Current medications and medication history
☐ Relevant diagnostic tests (ECG, vascular studies etc.)
☐ Relevant consult note

DETAILS ON SPECIFIC CONCERNS TO BE ADDRESSED

☐ See attached consult note or:

INSULIN ORDERS

New Insulin Order: ☐Initiation ☐Change
Order Set: ☐ Completed Below or ☐Attached: ☐Common ☐EMR ☐Other

Insulin Type:		☐Adjust insulin dose by 1-2 units or up to 20% prn to achieve CDA CPG glycemic target of ac 4-7 mmol/L and pc 5-10 mmol/lL or individual target of: _____
Dose and Time:		
Insulin Type:		☐Adjust insulin dose by 1-2 units or up to 20% prn to achieve CDA CPG glycemic target of ac 4-7 mmol/L and pc 5-10 mmol/lL or individual target of: _____
Dose and Time:		

☐ **Allow Registered Nurse and/or Registered Dietitian to reduce and/or discontinue the secretagogue dosage accordingly to avoid hypoglycemia**

☐**My signature authorizes, as per Organization's Medical Directives, the Registered Nurse to do blood glucose monitoring and request laboratory tests pertaining to Diabetes. Referring Physician or Allied Health Professional**_____

Signature_____ **Referral Date(mm/dd/yyyy)**_____

Referring Physician and/or Allied Health Professional will receive summary/progress report