# Central West Diabetes Education Program (DEP) Referral Form

Stand up to Diabetes / Faisons face au diabète

## STEP 1: Patient Information

Name: ____________________ Sex: M F DOB: ___/___/___ (MMM / DD / YYYY)

Address: ____________________

City: ____________ Postal Code ______ Health Card #: ____________

Phone (H) ____________ (W) ____________

Patient Primary Language Spoken: ____________ Translation Required? Yes ☐ No ☐

Has Family MD? Yes ☐ No ☐ OK For Group Education? Yes ☐ No ☐

## STEP 2: Priority

**Pediatric**: Immediate assessment in Emergency Department for newly diagnosed patients under 18 years of age and referral to DEP with Pediatric Services
**Pregnancy:** Referral to hospital-affiliated Endocrinologist at centre where patient will be delivering suggested

| Urgent (Within 48 Hrs) | | Urgent (Within 1-2 Weeks) | Non-Urgent (Next Available) |
|---|---|---|---|
| ☐ Uncontrolled Diabetes<br>• BG > 20mmol/L<br>• ketonuria > 1.5mmol/L | ☐ Newly Diagnosed Type 1 Diabetes (> 18 years old) | ☐ Gestational Diabetes | ☐ Pre-diabetes |
| | ☐ Pregnancy with Pre-existing Diabetes | ☐ Inpatient Admission Follow-Up | ☐ Type 2 |
| ☐ Recent treatment for<br>• diabetic ketoacidosis *or*<br>• nonketotic hyperosmolar hyperglycemia *or*<br>• severe hypoglycemia | ☐ Crisis that drastically affects individual's ability to manage their diabetes | ☐ Emergency Room Admission Follow-Up | ☐ Type 2 Insulin Initiation<br>☐ Insulin Pump Therapy |

**Reason** ☐ Initial care and education ☐ Self-management support ☐ Change in care plan ☐ Refresher education

## STEP 3: Present Diabetes Treatment

☐ Diet Only ☐ Diet + Anti-hyperglycemic Agent(s): ☐ Oral ☐ Insulin ☐ GLP-1 Agonist

☐ Medication List Attached (MedsCheck from local Pharmacist preferred) Please advise patient to bring medications to appointment

## STEP 4: Lab Results Required

Type 1 or Type 2 ☐ FBS, A1C, Lipid Profile, ACR Gestational ☐ 50g GTT 1 Hr ____ 75g GTT FBS ____ 1 Hr ____ 2 Hr ____

## STEP 5: 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 4-7mmol/L and pc 5-10mmol/L 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 4-7mmol/L and pc 5-10mmol/L or individual target of: ____ |
| Dose and Time: | | |
| **Oral Anti-Hyperglycemic Agents:** | ☐ Start ____<br>☐ Continue ____ | ☐ Discontinue ____ |

☐ 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 and/or the Registered Dietitian to do blood glucose monitoring and order laboratory blood glucose, HbA1C, lipid profile and microalbuminuria screen, and the Registered Dietitian to provide appropriate nutritional therapy.**

**Referring Physician:** ____________________

**Signature:** ____________________ **Referral Date** ___/___/___ (MMM / DD / YYYY)

**Referring Physician will receive summary / progress report**

### Confirmation of Appointment (Office Use Only)

Date Rec'd: ___/___/___ Triaged: ___/___/___ 1st Avail Appt: ___/___/___ Appt Date: ___/___/___ (MMM / DD / YYYY)