MUSKOKA ALGONQUIN HEALTHCARE

Adult Diabetes Education Program Referral Form
Fax to Huntsville: 705 704 9974
Fax to Bracebridge: 705 645 3983
Please note we do not see pediatric patients

Patient Information

Name:_____	Gender:_____
Address:_____	DOB(dd/mm/yy):_____
Date patient informed of referral:_____	City:_____ Postal Code:_____
Daytime Phone:_____	Health Card _____
Primary language spoken:_____	Alternate Phone:_____
Primary Care Provider:_____	Translation Required: ☐Yes ☐No
Diabetes Specialist or Endocrinologist:_____	

Diabetes Related Health Information and Reason for Referral

Type of Diabetes: **Type 1** ☐New ☐Established **Type 2** ☐New ☐Established ☐**Pre-Diabetes**
If Pregnant: ☐Type 1 ☐Type 2 ☐GDM Due Date: _____

Complication of Diabetes
☐ Nephropathy ☐ Neuropathy ☐ Cardiovascular disease ☐Mental health/cognitive concerns

Reason for Referral:

_____

_____

☐Education
☐ Severe hypoglycemia
☐ Inpatient, admitted related to diabetes
☐ Change in Insulin regimen
☐ Insulin Pump therapy
☐Recent treatment for DKA / HHS
☐Recent discharge from hospital/ER related to diabetes
☐Insulin initiation / GLP1 initiation
☐Pregnancy

Relevant Medical Information

Laboratory Tests: Most recent blood work, including A1c completed within the last 3 months. Creatinine, lipid profile, ACR and any other additional blood work would also be helpful.

Relevant Diagnostic Tests: Please attach relevant test reports

Medication and other issues:

_____

_____

_____

_____

_____

Referred by:_____ Contact Phone:_____ Fax:_____

Signature:_____ Referral date (dd/mm/yy):_____