



Diabetes Centre Educator Referral

Last Name	
First Name	
PHN#	Address
Birthdate (<i>dd-Mon-yyyy</i>)	Phone Number

Fax completed referral form to (403) 476-9626 or call (403) 955-8118

Date (<i>yyyy-Mon-dd</i>) _____		
Referral Information		
Reason for Referral		
<input type="checkbox"/> Insulin start (specific orders must be provided by referral source) <input type="checkbox"/> Medication adjustment (may include education about carbohydrate counting, insulin to carb ratio etc.) Medication adjustment includes: <ul style="list-style-type: none"> - Diabetes educator may adjust medications or make recommendations according to guidelines - Referring physician will be contacted if medication has been adjusted substantially - Referring physician will be notified at least every 2 months during therapeutic adjustment time - Periodic lab glucose values to validate patient blood glucose testing equipment and technique - HbA1C testing every 3 months if not done by referring physician 		
<input type="checkbox"/> Insulin pump therapy <input type="checkbox"/> Other (<i>specify</i>) _____		
<input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Type 2 Diabetes Date of Diagnosis (<i>yyyy-Mon-dd</i>) _____		
HgbA1c _____ Date (<i>yyyy-Mon-dd</i>) _____		
Medications (<i>list all</i>)	Factors that may affect learning (<i>check all that apply</i>)	
	<input type="checkbox"/> Language spoken (<i>specify</i>) _____ <input type="checkbox"/> Psychological (<i>specify</i>) _____ <input type="checkbox"/> Economic (<i>specify</i>) _____ <input type="checkbox"/> Other (<i>specify</i>) _____	
Referral Source		
Referring Physician/ Nurse Practitioner	Referring Prac ID	PCN
Address	Phone	Fax
Family physician (if different)	Family Prac ID	PCN
Physician's signature	Date (<i>yyyy-Mon-dd</i>)	Pager or contact number