MARKHAM STOUFFVILLE HOSPITAL CORPORATION

OUTPATIENT ADULT DIABETES EDUCATION SELF REFERRAL FORM

Forward to Diabetes Education Center at Markham Stouffville Hospital

☐ Markham Site
Health Services Building 3rd Floor
379 Church Street.
Markham, ON. L6B 0T1
Fax: 905-472-7533
Ph: 905-472-7527 (ext 1)

☐ Uxbridge Site
4 Campbell Drive
Uxbridge, ON, L9P 1S4
Fax: 905-852-2460
Ph: 905-852-9771 (ext 5260)

Name			
Gender ☐ M ☐ F	DOB (dd/mm/yyyy)	Health Card # (Mandatory)	
Address			
City	Postal code	Hm. Phone #	Cell Phone #
Family Physician Name			
Physician Address			
Physician Phone #			

- Reason for Self Referral (Please check all that apply):
  ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Pre-Diabetes
  ☐ No Diabetes but I am a High Risk
- Is diabetes a new diagnosis? ☐ Yes ☐ No
- Do you take medication for diabetes? ☐ No
  ☐ Yes, please specify:
  ☐ Pills ☐ Insulin ☐ Both pills and insulin

I give consent for the Diabetes Education Clinic to leave

☐ a voicemail message on my home/cell phone regarding appointment details

☐ a message with an adult family member regarding appointment details

Patient Signature _____ Date _____

I authorize any pertinent information required by the Adult Diabetes Education program to be released by my physician's office.

Patient Signature _____ Date _____