

## OUTPATIENT ADULT DIABETES EDUCATION REFERRAL

### Forward to Diabetes Education Center at Markham Stouffville Hospital

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

Name: \_\_\_\_\_ Gender:  M  F DOB (dd/mm/yyyy) \_\_\_\_\_

Address: \_\_\_\_\_ Hm. Phone # \_\_\_\_\_ Wk. Phone # \_\_\_\_\_

City: \_\_\_\_\_ Postal code: \_\_\_\_\_ Health Card # \_\_\_\_\_

Language spoken:  English  South Asian  
 Cantonese  Other Is translation required?  Yes  No

Referring MD: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**TYPE OF DIABETES** Date of Diagnosis: \_\_\_\_\_  
 Type 1  Gestational Diabetes ( \_\_\_\_\_ weeks)  
 Type 2  Type 1 in Pregnancy ( \_\_\_\_\_ weeks)  
 Prediabetes (Impaired Glucose Tolerance)  Type 2 in Pregnancy ( \_\_\_\_\_ weeks)  
 Impaired GTT of Pregnancy ( \_\_\_\_\_ weeks)  
*For Gestational Diabetes, will see Endocrinologist at DEC discretion*

**REASON FOR REFERRAL TO DEC**  
 \_\_\_\_\_  
 \_\_\_\_\_

**HEALTH HISTORY**

<input type="checkbox"/> See attached	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Dyslipidemia	Allergies: <input type="checkbox"/> NKA
<input type="checkbox"/> Cardiac Hx _____	<input type="checkbox"/> Retinopathy	<input type="checkbox"/> Foot/Skin Problems	
<input type="checkbox"/> Vascular disease	<input type="checkbox"/> Nephropathy	<input type="checkbox"/> Obesity	
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Mental Health Concerns	<input type="checkbox"/> Exercise Restrictions	
	<input type="checkbox"/> Other _____		

**LAB DATA (WITHIN THE LAST 3 MONTHS)**  See attached

Date	FBG/RBG	HbA1C	CHOL	HDL	LDL	TRIG	Creatinine	Microalbumin/Creatinine Ratio

**GESTATIONAL GTT:** Test date: \_\_\_\_\_ grams FBG \_\_\_\_\_ 1hr \_\_\_\_\_ 2hr \_\_\_\_\_

**CURRENT DIABETIC MEDICATIONS / DOSE / TIMING:**  
 Oral Hypoglycemic Agents: \_\_\_\_\_

**INSULIN:**  
 \_\_\_\_\_

**OTHER MEDICATIONS:**  
 \_\_\_\_\_

**INSULIN START / ADJUSTMENT:**  
 Request DEC educators make recommendations and fax back to physician's office for authorization  
**OR**  
 See attached Markham Stouffville Hospital corporation DEC "Orders for Treatment / Insulin Initiation / Adjustment" form

**Please note - To request an Endocrinology consult in addition to Diabetes Education:**

- For Dr. J. Bahrami, check box and fax to DEC (905-472-7533)
- For Dr. L. Bishara, check box and fax form to Dr. Bishara's office (905-201-4956) **AND** the DEC (905-472-7533)
- For Dr. E Kogan, check box and fax to DEC (905-472-7533)
- For Dr. P. Tsao, check box and fax to DEC (905-472-7533)

**NOTE: Patient will be contacted directly by the clinic with date & time of DEC visit.**

