West Toronto Diabetes Education Program

West Toronto DEP – Physician Referral Form

Fax Form to: 416 252 9141

CLINIC USE ONLY

Date Received: _____ (dd/mm/yyyy)

Appointment Date: _____ (dd/mm/yyyy)

Client Information

Last Name: _____ First Name: _____

Date of Birth (dd/mm/yyyy): _____ OHIP#: _____ (_____)

Gender Identity: ❒Female ❒Intersex ❒Male ❒Trans Female to Male ❒Trans Male to Female
❒Two-Spirit ❒Other (Please Specify)_____ ❒Do not know

Address: _____

City: _____ Postal Code: _____

Home Number: _____ Cell Number: _____

Primary Language: ❒English ❒Other_____ Interpreter Needed? Yes No

Referring Health Care Professional Information

Last Name: _____ First Name: _____

Phone Number: _____ Fax Number: _____

Reason for Referral

❒ Diabetes Prevention Education

❒ Self-Management Education

❒ Newly Diagnosed

❒ Insulin / GLP-1 start (write & attach order with signature)

Type of Diabetes

❒ At Risk

❒ Prediabetes (date diagnosed _____)

❒ Type 2 diabetes (date diagnosed _____)

❒ Other: _____

Relevant Medical History

❒Family History	❒ Hypertension	❒Dyslipidemia	❒PCOS	❒Acanthosis Nigricans
❒Mental Illness	❒ Smoker	❒Schizophrenia	❒CHF	❒Gestational Diabetes
❒Retinopathy	❒ Neuropathy	❒Nephropathy	❒CVD	❒Erectile Dysfunction
❒MI	❒ Macrosomia	❒Other: _____		

Concerns (specific issues for RD or RN to address or be aware of e.g. literacy, income, addictions, understanding of diabetes, stage of change, glycemic control, barriers to access):

_____

_____

_____

Current Medications: Please attach medication list with dosage, route, and frequency ❒ Attached

Labs: Please attach all recent blood work [HbA1C, FPG, lipid profile, ACR, eGFR] ❒ Attached