



# West Toronto Diabetes Education Program

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## 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#: \_\_\_\_\_ (\_\_\_\_)

I identify my gender as:  Female  Intersex  Male  Trans Female to Male  
 Trans Male to Female  Two-Spirit  Other (Please Specify) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Home Number: \_\_\_\_\_

Cell Number: \_\_\_\_\_

Email address (optional): \_\_\_\_\_

*I allow West Toronto DEP to contact me via email regarding updates and upcoming events?  Yes  No*

Best time to contact you?  am  pm

Primary Language:  English  Other \_\_\_\_\_ Interpreter Needed?  Yes  No

### Health Information

What type of diabetes are you living with?  At risk  Pre-diabetes  Type 2

How do you manage your diabetes?  Diet/Exercise  Oral Medication  Insulin

How long have you lived with diabetes? \_\_\_\_\_

Type of service requested:  Individual counseling  Group Education Session  Physical Activity

### What would you like to learn about? (Check all that apply)

Physical Activity  Glucometer Reading  Medication/Insulin  
 Meal Planning  High and Low Blood Sugars  Stress Management  
 Label Reading  Smoking Cessation  Complications  
 Weight Management  Other: \_\_\_\_\_