Ontario Health atHome

Centralized Diabetes Intake Referral Form

For Access to Diabetes Education Programs and the Centre for Complex Diabetes Care

Phone: 1-888-997-9996 Fax: 1-905-444-2544 Toll Free Fax: 1-844-731-2161

Referral forms can be found at: https://ontariohealthathome.ca/document/ce-centralized-diabetes-intake-referral-form/

Patient Information

Name: ______ Gender: ______ DOB (dd/mm/yy): ______

Address: ______ City: ______ Postal Code: ______

Date patient informed of referral: ______ Health Card Number: ______

Daytime Phone: ______ Alternate Phone: ______

Primary language spoken: ______ Translation required: ☐ Yes ☐ No

Primary Care Provider: ______ Primary Care Provider contact: ______

Diabetes Specialist or Endocrinologist* ______ Diabetes Specialist contact: ______

Diabetes-Related Health Information and Reason for Referral

(To enable us to determine the appropriate program, as well as urgency for assessment, please fill out as completely as possible)

Type of diabetes: *Type 1* ☐ new ☐ established *Type 2* ☐ new ☐ established ☐ Pre-diabetes If pregnant: ☐ Type 1 ☐ Type 2 ☐ GDM

Due Date (dd/mm/yy): ______

Comorbidities:
- ☐ later stages of kidney disease or renal failure
- ☐ neurological conditions such as stroke, progressive neuropathy
- ☐ recurrent cardiac conditions such as congestive heart failure, myocardial infarct, angina
- ☐ retinopathy or vision threatened
- ☐ mental health/cognitive concerns
- ☐ uncontrolled hypertension
- ☐ obesity

Other Issues:
- ☐ recent repeated hospital admissions that may benefit from specialized out-patient follow-up
- ☐ recent repeated emergency room visits that may benefit from specialized out-patient follow-up
- ☐ other barriers (e.g.: financial, frail elderly, mobility, etc.): ______

Reason for referral: ______

☐ BG 15-20 mmol/L	☐ BG >20 mmol/L	☐ A crisis that drastically affects the individual's ability to manage their diabetes
☐ Recent treatment for DKA / HHS	☐ Severe hypoglycemia	☐ Education
☐ A1C 8.5 – 10%	☐ A1C > 10%	☐ Recent discharge from hospital/ER related to diabetes
☐ Insulin initiation / GLP1 initiation	☐ Change in Insulin regimen	☐ Inpatient, admitted related to diabetes Expected date of discharge: ______
☐ Pre-pregnancy counselling	☐ Insulin Pump therapy	

*Please note that if your patient requires a referral to an endocrinologist, referral must be initiated by MD.

Medication: Please attach current medications or list here:

Relevant Medical History

Laboratory Tests:
Most recent blood work, including A1C completed within the last 3 months **must be attached**. Creatinine, lipid profile, ACR and any other additional blood work would also be helpful.

Relevant Diagnostic Tests:
Please attach relevant test reports.

Referred by: ______ Contact phone: ______ Fax: ______

Signature:______________________________ Referral date (dd/mm/yy):______________________________

CE-CDI-5 (12/25)