South Riverdale COMMUNITY HEALTH CENTRE

Toronto Central Diabetes Program Referral Form
for Type 2 Diabetes and Prediabetes

DECNET Diabetes Education Community Network of East Toronto

Refer immediately to an endocrinologist if client is pregnant, planning pregnancy or, or has type 1 diabetes

Fax to: 416-699-9835 Or mail to: DECNET, 955 Queen St. E. Toronto M4M 3P3

Personal Information:
Name: ____________ **D.O.B. (m/d/y):** ______

Home Address: ____________ City: ______

Postal Code: ______ Daytime contact phone #: ______ **Gender:** ☐ M; ☐ F; ______

Type of Diabetes: ☐ Prediabetes; ☐ Type 2 Diabetes; ______ Diabetes Medication: ☐ none; ☐ pills; ☐ insulin; ☐ ______

Preferred program location: ☐ Near home; ☐ Near this major intersection: ______

If a specific location is preferred please indicate here: ☐ Queen St. East/Carlaw Ave. ☐ Danforth Ave./Greenwood Ave. ☐ Victoria Park Ave./Danforth Ave.

Program preferences: Language: ☐ English ☐ Chinese ☐ South Asian ☐ Other ______

Service Access challenges: ☐ Mental health challenges: ______; ☐ Developmental challenges: ______

☐ Mobility issues; ☐ Homelessness/housing issues; ☐ Problematic drug and/or alcohol use; ☐ Non-insured status (refugee, new immigrant);

☐ No family doctor/nurse practitioner; ☐ Other: ______

Referral Made by:
☐ Myself (self-referral)

☐ Family physician ☐ Nurse practitioner ☐ Endocrinologist

☐ Other professional/organization (☐ *Progress reports desired*)

Referral Made for:
☐ Diabetes self-management education

☐ Prediabetes self-management education

☐ Insulin initiation or adjustment: *Signed order (page 2) must be attached*

☐ Tele-ophthalmology screening for diabetic retinopathy

Other: ______

Referral Source Contact Information (stamp):

Name (printed):

Profession:

Organization:

Address:

Tel:

Fax:

To be Completed by Health Care Provider:
Medications (name/dose/frequency): ☐ none ☐ see attached medication list

Oral antihyperglycemic agents: ☐ none or: ______

Insulin/injectable antihyperglycemic agents: ☐ none or: ______

Other medications: ☐ none or: ______

Laboratory Result/Date (used to determine urgency): ☐ see attached labs

A1C		OGTT: 0 hr		LDL		TG		ACR	
FBG		2 hrs		TC/HDL		eGFR			

Medical History ☐ see attached

☐ Type 2 diabetes	☐ Cardiovascular disease	☐ Neuropathy
☐ Prediabetes	☐ Retinopathy	☐ Foot/wound concerns:
☐ Dyslipidemia	☐ Nephropathy	☐ Planning pregnancy *(endocrinology referral also required)*
☐ Hypertension	☐ Other/comments:	

Administration Use Only:
☐ Diabetes program/site: ______

Chart #: ______ Date received (m/d/y): ______ Date of 1st appointment (m/d/y): ______

If you have any questions, please call: 416-461-9042 or 416-461-9043