Diabetes Education Centre
North Bay Regional Health Centre

Centre d'éducation sur le diabète
Centre régional de santé de North Bay

Medical Referral for Adult Diabetes Education

Referrals will be accepted from Physicians, Physician Assistants, Nurse Practitioners and Midwives.
Please note we are an education program and DO NOT prescribe medications at the Diabetes Education Centre.

Referring Practitioner:	Referral Date:
Patient's Name:	Date of Birth:
Health Card Number:	Gender: □ Male □ Female □ Other
Patient's Full Mailing Address:	
Patient's Phone Number (s):	
Language preference: □ English □ French □ other:	□ Visual or □ Hearing Impairment

Year of Diagnosis: _____; **Diagnosis:** □ PreDM □ T2DM □ T1DM □ Steroid-induced □ DM in Pregnancy*

*Please consider endocrinology referral if you predict your patient will require medication management in pregnancy.

Reason for Referral (check all that apply):
□ Diabetes education □ Assess for changes to current oral agents □ Assess for changes to current injectable/insulin regime
□ GLP-1 Initiation/Injection teaching. *Please ensure patient has been provided with prescription and dosing instructions.*
Type: _____ Dose: _____ Titration Orders: _____
_____

□ **Insulin Start (*We do not prescribe insulin;* *therefore, please send the insulin prescription with the referral or a diabetes educator will assess the patient and provide insulin prescription recommendations to your office).*
Insulin type(s): _____ Dose(s)/time(s): _____
_____
□ I would like oral agents **continued** with insulin start. Comments: _____
_____
□ I authorize the RN/RD diabetes educator to teach patient self-adjustment of insulin up to 20% total daily dose based on pattern management and to decrease up to 50% for planned physical activity.
□ I do **NOT** authorize the DEC RN/RD to teach or support patient with self-insulin dose adjustment.

Complications, Risks, Barriers to self-care: _____

Current Medications: □ Current medication list attached Patient's Pharmacy: _____
Recent Lab Results □ Attached [i.e., HbA1c, FBG/RBG, OGTT (50 and 75 g), Lipids, eGFR, ACR, TSH]
Results (if not attached): _____
_____

Practitioner Signature: _____ **Date:** _____

If you have not completed referral with required information, it will be returned to your office for completion prior to booking an appointment for your patient. Triaging of patient appointment will be based on the DEC Triage Criteria. Thank you in advance.

Office use: Date received: _____ Date reviewed: _____ Appointment: _____
RHC 2293 April 2021

Full Time Service:

☐ **North Bay Regional Health Centre**
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Part Time Services:

☐ **West Nipissing General Hospital**
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☐ **Hôpital de Mattawa Hospital**
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