Sundec

Sunnybrook Diabetes Education Centre Patient Referral Form

Phone: 416 480-4805/ Fax: 416 480-4283

Name: _____ Home Telephone: _____
Address: _____ Cell Phone : _____
_____
Date of Birth: _____ Health Card: _____ VC: _____

PATIENTS ARE CONTACTED DIRECTLY

Type of Diabetes and Duration

Type 1_____ Duration_____

Type 2_____ Duration_____

Pre Diabetes (IGT, IFG)_____

At Risk for DM (prevention)_____

Medications (type and dose)
Diabetes Oral Agents

Other Medications

Medical History
___Hypertension ____Hyperlipidemia
___Nephropathy ____Retinopathy
___Neuropathy ____PCOS
___Depression
Other

Lab Results
A1C_____ Date_____
FPG_____ Date_____
OGTT_____ Date_____
Total Cholesterol_____ Date_____
HDL_____/LDL_____/TG_____
Chol/HDL ratio_____ Date _____
eGFR _____ Date_____
MA/Cr ratio_____ Date_____
Creatinine _____ Date_____

Initiate insulin ___No ___Yes

Type of insulin and dose

My signature authorizes the registered nurse to make up to a 15% insulin dose adjustment as necessary

Physician signature

Date_____

Referring Physician's Name, mailing address and phone number.

Mail or Fax to: Corrie P **Sunnybrook Health Sciences Centre, A119**
Phone: 416 480-4805/ Fax: 416 480-4283 **2075 Bayview Avenue, Toronto ON, M4N 3M5**