SUNDEC – SELF REFERRAL FORM

Sunnybrook Diabetes Education Centre

2075 Bayview Avenue, Toronto On, M4N 3M5 Phone: 416 480-4805/ Fax: 416 480-4283

Name: _____

DOB: _____

Address: _____

_____

_____

Health Card #_____ V.C _____

HFN :_____

Best Contact # : _____

Alt. Phone Number: _____

Do you know what type of Diabetes you may have?

- ○ Type 1 - Duration_____
- ○ Are you on a Pump??
- ○ Type 2 - Duration_____
- ○ Pre Diabetes (IGT, IFG)
- ○ At Risk for DM (prevention)

How did you hear about us? _____

Medications ***Please bring a list of medications***

Diabetes Medications:

_____

_____

_____

Other Medications:

_____

_____

ADMIN NOTES :_____

_____

_____

_____

NURSING SECTION

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_____

Family Doctor: _____
Tele #: _____

Endocrinologist: _____
Tele #: _____