Haliburton Highlands Diabetes Education Network
P.O. Box 30, Minden, ON K0M 2K0
(705) 286-2140 ext 3296
Fax: (705) 286-3146
Email: diabetes@hhhs.ca

Haliburton Highlands Health Services Diabetes Education Network Referral Form

Patient Information

Name: _____
Address: _____
City: _____ Postal Code: _____
Date of Referral: _____
PCP: _____
PCP Contact: _____

Gender: _____ DOB (dd/mm/yy): _____
Phone Number: _____
Alternate Phone: _____
Health Card Number: _____
Diabetes Specialist: _____
Diabetes Specialist Contact: _____

Reason for Referral

Type of diabetes: Type 1 ☐New ☐Established Type 2 ☐New ☐Established ☐Pre-diabetes ☐Gestational
Reason for referral: _____

☐ HbA1c > 10%	☐ Change in medication	☐ Recent hospitalization related to diabetes
☐ HbA1c 8.5-10%	☐ Initiation of new medication	☐ Severe hypoglycemia
☐ HbA1c > 7%	☐ Insulin or GLP1 initiation	☐ Education
☐ HbA1c at target	☐ Ongoing insulin titration/adjustment	☐ Change in ability to self-manage diabetes

Diabetes-Related Health Information

Comorbidities:

☐ Renal impairment	☐ CAD	☐ Previous stroke/TIA
☐ Hypertension	☐ Retinopathy	☐ Obesity
☐ Hyperlipidemia	☐ Neuropathy	☐ Other: _____

Barriers affecting care: _____

Medications: Please attach current medication list.
Laboratory tests: Please attach more recent blood work including A1c, creatinine, lipid profile and any additional pertinent lab work.

Signature by MRP required in order to authorize the diabetes educator to educate the patient to adjust insulin by 10% of the patient's total daily dose as defined by the Canadian Diabetes Association Clinical Practice Guidelines for Diabetes Management in Canada.

Signature: _____

Referring Provider
Name: _____
Contact Number: _____
Fax Number: _____
Date: _____

Signature: _____

OFFICE USE ONLY
Date Received: _____
Priority Level: _____
Date of Initial Contact: _____
Date of Appointment: _____