youville Diabetes Centre

33 Marion St. Wpg, R2H 0S8 (204)233-0262
www.youville.ca

REFERRAL FORM
Fax to 204-233-1520

For triage purposes, lab results and medications MUST BE completed or attached

Client information:

Last Name: _____
Name: _____(m) (f)
Address: _____
_____
Postal Code: _____
Tel: (H) _____(W) _____
(C) _____
D.O.B: (d/m/y) _____/ _____/ _____
MH No: _____
PHIN: _____

Physician/NP/PCP Name:
_____
Address: _____
_____
Postal Code: _____
Telephone: _____
Fax : _____
Preferred Language: _____
Interpreter Required: ☐Yes ☐ No
Problems with: ☐ Vision_____ ☐ Hearing

Type of Diabetes: ☐ Type 1 ☐ Type 2 ☐ Pre-diabetes **(R2M & R2N Postal Code ONLY)**
☐ Gestational – EDC_____/_____/_____ 50gm screen:1 hr pc _____ Date_____
– OGTT: FBS _____ 1 hour _____ 2 hour_____ Date_____

Duration of Diabetes: ☐ New Number of years: _____

Complications: ☐ CVD ☐ Hypertension ☐ PVD ☐ Neuropathy (type:_____)
☐ Nephropathy ☐ Retinopathy ☐ Foot problems ☐ Sexual Dysfunction

Other Health Issues: ☐ Mental Health ☐ Learning Deficit ☐ Cognitive Deficit
Other (e.g. Celiac Disease, mobility, etc.):_____
_____

Current Diabetes Treatment (Attach Medication List with ALL Meds and Dosages):
☐ Lifestyle **(R2M, R2N Postal Code ONLY)**
☐ Oral Agent(s) _____
☐ Insulin/Injectable therapies _____
☐ Insulin Pump (include rates) _____
☐ Insulin Start Order _____

Insulin dose adjustment to achieve optimal glycemic control to be done by: (select one)
☐ **Certified Diabetes Nurse Educator and MD/NP**
☐ **MD/NP only**

Lab Results (Labs to be attached):

Fasting blood sugar _____ Date _____ Total cholesterol _____ Chol ratio_____ Date _____

Hemoglobin A_1C _____ Date _____ Triglyceride _____ LDL _____HDL _____ Date _____

Albumin/creatinine ratio _____ Date _____Creatinine _____ Date _____ eGFR _____ Date _____

I have explained this referral and client is agreeable and aware of the diagnosis on this referral
Physician/NP/PCP Signature: _____Date:_____