Fax to: ☐ Tillsonburg District Memorial Hospital
Telephone: 519-842-3611 Ext. 5362
Fax: 519-688-5602

☐ Alexandra Hospital, Ingersoll
Telephone: 519-485-9611
Fax: 519-485-9601

Diabetes Education Program (DEP)
Referral Form

Patient: Last name First name		**Address:**
Phone:	**Date of Birth:** (yyyy/mm/dd)	**Health Card Number:** **Version Code:**

Check Type: ☐ Type 1 ☐ Type 2 ☐ Prediabetes ☐ Type1/Type 2 pregnancy
☐ Gestational Diabetes Mellitus ☐ At Risk for Diabetes (dietitian only)

Date of Diagnosis (yyyy/mm/dd): ___________________________

Other Pertinent Diagnosis: ☐ Mental Health ☐ Dyslipidemia ☐ Hypertension ☐ Other: ____________________

____

List All Diabetes Medications and Dose: ____

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____

Reason for referral: ____

____

☐ Newly Diagnosed ☐ Established ☐ Social Work Support ☐ **Insulin Initiation**: Attach a signed copy of patients insulin prescription.

Medical Directive: Referral to the DEP may include adjustment of insulin & non insulin injectable / Oral Antihyperglycemic Agents

Physician

Print Name: ___________________________________ **Date:** (yyyy/mm/dd) _________________________

Signature: _____________________________________

Diabetes Education Program Office Use Only:	
Referral Received (yyyy/mm/dd): _______________________________	**Appointment Date (yyyy/mm/dd):** _______________________**Time (2400hours)** ________