Royal Victoria Regional Health Centre

PATIENT NAME: _____

DOB: _____

HRN: _____

Adult Diabetes Clinic Referral
Medicine Treatment Clinic

Phone: 705-728-9090 Ext: 23300
Fax: 705-728-3039

This referral constitutes authorization for certified Diabetes Educators at RVH to provide Diabetes Education according to Diabetes Canada Clinical Practice Guidelines.

URGENCY: 4 Weeks ☐ 2 Weeks ☐ First Available ☐

REASON FOR REFERRAL:

☐ Outpatient

☐ New Diagnosis

☐ Prediabetes ☐ Type 1 ☐ Type 2 ☐ Previous DM Education Y ☐ N ☐

☐ New to Insulin Type of Insulin _____ Dose/Units _____ Frequency _____

☐ New to Oral AHA's

☐ Glucose Meter Teach

☐ Diet Education

Comments:

Current Diabetes Medications:

Other Medications:

Relevant Lab/Diagnostic Tests Pending or Results - Please attach with referral or fax to 705-728-3039

☐ Internal Medicine Physician with Diabetes Educator

☐ Referring Physician authorizes Diabetes Educators to perform Point of Care HbA1C q3 months

Signature of Referring Physician _____ Date 09/15/2021

Referring Physician Name Print _____ Physician Billing Number _____

Physician Office Phone _____ Physician Office Fax _____

For Office Use

Triage By: _____ Triage Date: _____

Action Plan:

_____