Mackenzie Health
Diabetes Education Program Referral

955 Major Mackenzie Drive West, Suite 340
Phone: 905-883-2211 Fax: 905-883-0772

Patient Information:

Last name: ______________________ First name: ______________________ M☐ F☐ DOB: ____________ YYYY·MM·DD

Address: ____

OHIP#: __________________ Version Code: ______ ☐Non-insured

Primary Phone #: ____________________ Secondary Phone #: ____________________

Name of Parent/Guardian: ____________________ Language Preferred if not English: ____________________

Allergies: ____ ☐NKA

Type of Diabetes:

- ☐ **At Risk** for Diabetes
- ☐ **Prediabetes**
- ☐ **Type 2** ☐Diet/Lifestyle ☐Oral Meds ☐Insulin/injectable
- ☐ **Type 1** ☐Newly diagnosed ☐Pump (attach settings)
- ☐ **Pregnant** with Gestational Diabetes - ______weeks
- ☐ **Pregnant** with ☐Type 1 ☐Type 2 - ______weeks

Reason for Referral:

- ☐ **Diabetes Education**
- ☐ **Diabetologist/Endocrinologist** consult
- ☐ **Start Insulin/Injectable –** order and signature required
- ☐ Retinal Screening
- ☐ ________________________________

(In-person, phone, virtual video and OTN appointments are available)

Insulin/Injectable Order:

Insulin/Injectable Order	Dose:	Time:

☐ Continue current diabetes oral medications ☐ After insulin/GLP-1 Analog start, stop: ____________________

Current Medications:

Current Medications:	Dose	Route	Freq.	Current Medications	Dose	Route	Freq.

Additional Considerations:

- ☐ Hypertension
- ☐ Dyslipidemia
- ☐ Cardiovascular disease
- ☐ Foot health concerns
- ☐ Neuropathy
- ☐ Nephropathy
- ☐ Mental health concerns
- ☐ Retinopathy
- ☐ Other: ________________________________

Referring Health Care Provider Information:

A report of the visit will be provided to:

Name:

Address:

Phone:

Fax:

Billing number:

Physician Orders:

		Yes	No
1.	**I authorize the Diabetes Educator/s to adjust this patient's insulin based on the DEC's Medical Directive/Protocol** (available from the DEC). The Diabetes Educator will provide education on how to self-titrate insulin based on blood glucose, carbohydrate intake and physical activity.	☐	☐
2.	**If clinically indicated, I authorize the DEC to arrange an urgent Endocrinology consult**	☐	☐

Physician's signature: ______________________________ MD