



Grand Bend Area Community Health Centre

Date: _____
Name of Patient: _____ DOB: _____
Address: _____ Postal Code: _____
Phone # (Home): _____ (Work): _____
OHC#: _____

REASON FOR REFERRAL: Type of Diabetes _____

New Diagnosis
OR

Established Diabetes _____ years

LAB DATA: (Please provide 2 glucose results for new diagnosis)

		Result
Plasma glucoses 1. _____ ac/pc/random Date: _____	Cholesterol	_____
2. _____ ac/pc/random Date: _____	HDL	_____
A1C _____ Date: _____	LDL	_____
Creatinine: _____ Date: _____	Ratio	_____
Albumin/creatinine ratio: _____ Date: _____	Triglycerides	_____
	Date	_____

LAB DATA is attached: Yes No

Diabetes Medications:

All other Medications:

****Please Note: for insulin starts/insulin change – notify Diabetes Nurse Educator directly)**

Other Related Health Problems:

Retinopathy Neuropathy HTN CAD Nephropathy
 Overweight Foot Problems Psychosocial Smoker Exercise Restrictions
 Other: _____

Is the patient appropriate for group education? Yes No

Physician/Nurse Practitioner Referring: _____
Address: _____ Postal Code: _____
Phone #: _____ Fax #: _____
Signature of Referring Physician/Nurse Practitioner: _____