VAUGHAN COMMUNITY HEALTH CENTRE

Vaughan CHC Diabetes Education Program
Physician Referral Form

9401 Jane St, Ste. 206, Vaughan ON, L6A 4H7
Phone: 905-303-8490 ext. 2 Fax: 905-303-0320

Patient Information

Last Name	First Name	❑M	❑F	❑Other
Date of Birth (YYYY/MM/DD):	OHIP#: ❑ Non-Insured:			Expiry Date (MM/DD):
Address:				
Primary Phone #:	Preferred Language:			

Preferred Method of appointment: ❑ Virtual Consult – ❑ Telephone – ❑ Video (Ontario Telemedicine Network)
❑ In person Visit
❑ Diabetes Group – Zoom

Reason For Referral:

❑ Diabetes Education ❑ Uncontrolled Diabetes

❑ Start Insulin/GLP-1 (Write Order/Attach Rx; sign below)

Type of diabetes: ❑ Type 2 ❑Prediabetes ❑ At risk
Diagnosis: year

Laboratory Results:

Please attach recent blood work (HbA1C, eGFR, lipid profile, etc.) ❑Attached

Current Medications:	Dose	Route	Frequency	Current Medications:	Dose	Route	Frequency

Insulin or GLP 1 Analog Start Order	Dose	Time

❑Continue current diabetes oral medications ❑Stop these medications after Insulin/GLP-1 start

Additional health considerations:

❑Hypertension ❑Nephropathy ❑Cardiovascular disease ❑Retinopathy
❑Dyslipidemia ❑Neuropathy ❑Foot problems ❑Other

Allergies: ❑No Known Allergies

Referring Health Care Provider Information: **Physician Orders:**

Please send the consult notes to: **Name:**_____ **Address:**_____ _____ **Phone:**_____ **Fax:**_____ **Billing Number:**_____	**I authorize the Diabetes Educator to adjust this patient's insulin based on the DEP's Medical Directive.** The Diabetes Educator will provide education on how to self-titrate insulin based on blood glucose, carbohydrate intake, and physical activity. **Physician Signature:**_____ **Date:**_____	❑**Yes** ❑**No**