St. Paul's Hospital

DIABETES HEALTH CENTRE REFERRAL

FAX # 604-806-8572

Appointment Date: ______________________
(To be completed by Clerk at the Diabetes Centre)

PLEASE PRINT CLEARLY

Last name: ______________________ First name: ______________________

Date of birth: (dd-mon-yyyy) ______________________ PHN No: ______________________

Mailing address: ______________________

City: ______________________ Province: __________ Postal Code: ______________________

Home phone number: ______________________ Daytime contact number: ______________________

Referring MD

Printed name: ______________________ Signature: ______________________ MSP No.______________

Phone number: ______________________ Fax number: ______________________

Non English speaking patients are required to bring an interpreter to their appointments.

LAB WORK

PLEASE FAX RECENT (within the last month) **LAB VALUES TO THE DIABETES CENTRE**
Fasting glucose, A1C, total cholesterol, LDL, HDL, Triglycerides, total/HDL ratio, eGFR, microalbumin/creatinine ratio

FAX # 604-806-8572. If you have any questions please call 604-806-8357.

Reason for Referral

☐ Pre Diabetes (IFG/IGT) ☐ Type1 ☐ Type 2 Age at diagnosis: ______________________

☐ Insulin pump ☐ Other: ______________________

Diabetes medications/dose: ______________________

Additional medications/dose: ______________________

Related Medical Issues:

☐ Heart Disease ☐ Dyslipidemia ☐ Hypertension ☐ Nephropathy ☐ Retinopathy ☐ Neuropathy

☐ Depression ☐ Other: ______________________

Endocrinology Referral: ☐ **Yes** ☐ **No**

Please note: The patient will be seen by one of our endocrinologists if one of the following is present:

a) A1c above 10%
b) A1c remains above 8% at 6 months after completing our education program

Your referral will be acknowledged within 3 days.
Our office will make an appointment with your patient within the next 2 weeks.

Form No. DB145 (R. Sep 25-13)