



St. Paul's Hospital

**DIABETES HEALTH CENTRE
REFERRAL
FAX # 604-806-8572**

PLEASE PRINT CLEARLY

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

Last name: _____ First name: _____
Date of birth: (dd-mon-yyyy) _____ PHN No: _____
Mailing address: _____
City: _____ Province: _____ Postal Code: _____
Home phone number: _____ Daytime contact number: _____
Language: English Other: (specify) _____ Patient will bring interpreter Interpreter to be booked

Referring MD

Printed name: _____ Signature: _____ MSP No. _____
Phone number: _____ Fax number: _____

**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

FAX completed Referral and lab results to the Diabetes Health Centre - 604-806-8572