St. Paul's Hospital

DIABETES HEALTH CENTRE REFERRAL

FAX # 604-806-8572

Complete ALL SECTIONS or referral will be returned.

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: ____________

Referring MD

Printed name: ____________ **Signature:** ____________ **MSP No.** ____________

Phone number: ____________ **Fax number:** ____________

Reason for Referral

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

☐ Insulin pump ☐ Other: ____________

PATIENT'S LANGUAGE: ☐ English ☐ Other: (specify) ________ ☐ Patient will bring interpreter ☐ Book interpreter

Diabetes medications/dose: ____________

Additional medications/dose: ____________

Related Medical Issues:

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

☐ Depression ☐ Other: ____________

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.

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

Form No. DB145 (R. Apr 25-19)