Stand up to Diabetes

Diabetes Education Self-Referral Form

CLINIC USE ONLY
Date received: **Appointment date:**

Patient Information

Name ______________________________ M ☐ F ☐ **Date of birth:** ______________
Last name First name

Address ______________________________ **Phone:** Home ( )
Street City/Town Postal code Work ( )
OHIP# ______________ **Exp** ______ Mobile ( )
MM YYYY

Allergies: ______________________________

Reason for referral? ☐ **Prediabetes** ☐ **Type 1** ☐ **Type 2** ☐ **Gestational (with pregnancy)**

How long have you had diabetes? ______________________________

Previous diabetes education? Yes ☐ No ☐ When? ______________ Location? ______________

Do you have or have you ever experienced any of the following? (Please check all that apply)

☐ Family history of diabetes
☐ High blood pressure
☐ High cholesterol
☐ Gestational diabetes
☐ Overweight / Obesity
☐ Smoker
☐ Heart disease
☐ Heart failure
☐ Heart attack
☐ Retinopathy (Eye complications)
☐ Neuropathy (Nerve damage)
☐ Nephropathy (Kidney problems)

Medications: ______________________________

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Do you have a Family Physician? Yes ☐ No ☐

Family Physician Contact Information:

Name: ______________________________
Address: ______________________________
Phone: ______________ **Fax:** ______________

☐ **I authorize the staff from the Diabetes Education Program to contact my family physician to obtain records of my most recent laboratory results.**

Patient signature: ______________________________ **Date:** ______________