Haliburton Highlands Diabetes Education Network
P.O. Box 30 Minden, On K0M 2K0
(705) 286-2140 ext 3296
Fax: (705) 286-3146
Email: diabetes@hhhs.ca

Haliburton Highlands Health Services Diabetes Education Network Referral Form

Patient Information

Name: ____
Address: ____
City: ________________________ Postal Code: ___________
Date of referral: ______________________________________
PCP: ____
PCP contact: ____

Gender: __________ DOB (dd/mm/yy): ________
Phone number: ____________________________
Alternate Phone: ___________________________
Health Card Number: _______________________
Diabetes Specialist: _________________________
Diabetes Specialist Contact: _________________

Reason for Referral

Type of diabetes: Type 1 ☐new ☐established Type 2 ☐new ☐established ☐Pre-diabetes ☐Gestational
Reason for referral: ____

- ☐ HbA1c > 10%
- ☐ HbA1c 8.5-10%
- ☐ HbA1c >7%
- ☐ HbA1c at target

- ☐ Change in medication
- ☐ Initiation of new medication
- ☐ Insulin or GLP1 initiation
- ☐ Ongoing insulin titration/adjustment

- ☐ Recent hospitalization related to diabetes
- ☐ Severe hypoglycemia
- ☐ Education
- ☐ Change in ability to self-manage diabetes

Diabetes-related Health Information

Comorbidities:

☐ renal impairment	☐ CAD	☐ previous stroke/TIA
☐ hypertension	☐ retinopathy	☐ obesity
☐ hyperlipidemia	☐ neuropathy	☐ other: ________________________________

Barriers affecting care: ____

Medications: Please attach current medication list
Laboratory tests: Please attach more recent blood work including A1c, creatinine, lipid profile and any additional

Signature by MRP required in order to authorize the diabetes educator to educate the patient to adjust insulin by 10% of the patient's total daily dose as defined by the Canadian Diabetes Association Clinical Practice Guidelines for Diabetes Management in Canada.

Signature: _____________________

Referring Provider
Name: ___________________________________
Contact Number: ___________________________
Fax Number: ______________________________
Date: ____________________________________

Signature: _____________________

OFFICE USE ONLY
Date received: _________________
Priority Level: __________________
Date of initial contact: ___________
Date of appointment: ____________

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