Mississauga Halton Diabetes Services Referral Form

PHONE # 1-855-223-6847 FAX # 905-338-0442 *(Toll Free fax:1-855-338-0442)*

To submit referrals online, visit www.mhcentralintake.com/eReferral

★**Patient Information** □ **Adult** □ **Pediatric** (<18 Years)

Last name: First name: □ Male □ Female

DOB(dd/mm/yyyy): OHIP#: Preferred language:

Phone: Email:

Address: Postal Code:

PRIORITY OF REFERRAL (See reverse for Guidelines) □ **Urgent** □ **Semi-Urgent** □ **Non-Urgent**

Reason For Referral:

Patient Preferred Program:

Refer to Chronic Disease Self Management Program (Maximize Your Health) □ Yes □ No

★**Diabetes Diagnosis**	**Duration In Years** □ **New** □ **1-5** □ **6-10** □ **10+**
□ Type 1 □ Steroid-Induced	□ **Gestational Diabetes** **Please attach blood work** **EDC:** (dd/mm/yyyy)
□ Type 2 □ Pre-diabetes □ GDM	□ Newly Diagnosed GDM □ Repeat GDM
	□Pre-existing Pre-Diabetes □ Pre-existing Type 2 □ Pre-existing Type 1
	Delivery Hospital: **THP:** □ CVH □ MH **HHS:** □ GH □ MDH □ OTMH

Complications and Risks □ **None**

□ Hypertension	□ Dyslipidemia	□ PVD □ Foot Ulcers	□ CVD	□ Neuropathy	□ CKD	□ Retinopathy	□ Other (Please Specify)
□ Cognitive Impairment	□ Depression	□ Substance Abuse	□ Smoker	□ Speech Impairment	□ Obesity	□ Mobility Impairment	

★**Assessment Data** □ **Lab Results Attached**

Date of Lab Findings (dd/mm/yyyy)	FBG	★**A1C**	LDL	eGFR	ACR

★**Current Medications** Please provide (name/dose/frequency) □ **List attached** □ **No Diabetes Medications**

HOSPITAL USE ONLY: IS THIS PATIENT BEING DISCHARGED FROM A HOSPITAL? □

No □ Yes □ Inpatient □ Emergency

Hospital Site THP: □ CVH □ MH HHS: □ GH □ MDH □ OTMH

Family Physician: □ **The client does NOT have a primary care physician**

★**Referral Source Information:** □ MD □ NP □ Self □ MDT □ Pharmacist □ Other _____

Print Name: **Phone:**

Address: **Fax:**

Referral Date:

Signature Required for any of the Following:

□ *Insulin Initiation by RN and/or RD (* ***Must be accompanied by completed Insulin prescription form*** *)*

Is the patient currently seeing an endocrinologist? □*No* □ *Yes, Name:* _____

□ *Refer patient to an endocrinologist*

Signature: **Billing #:**

★**INDICATES INFORMATION REQUIRED TO PROCESS REFERRAL**