



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** **5-10** **10+**

<input type="checkbox"/> Type 1	<input type="checkbox"/> Steroid-Induced	Gestational Diabetes	<input type="checkbox"/> Attach blood work	EDC: (dd/mm/yyyy)
<input type="checkbox"/> Type 2	<input type="checkbox"/> Pre-diabetes	<input type="checkbox"/> Pre-existing Type 1	<input type="checkbox"/> Pre-existing Type 2	<input type="checkbox"/> Newly Diagnosed
Delivery Hospital: THP: <input type="checkbox"/> CVH <input type="checkbox"/> MH HHS: <input type="checkbox"/> GH <input type="checkbox"/> MDH <input type="checkbox"/> OTMH				

Complications and Risks **None**

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Dyslipidemia	<input type="checkbox"/> PVD	<input type="checkbox"/> CVD	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> CKD	<input type="checkbox"/> Retinopathy	<input type="checkbox"/> Other (Please Specify)
<input type="checkbox"/> Cognitive Impairment	<input type="checkbox"/> Depression	<input type="checkbox"/> Foot Ulcers	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Smoker	<input type="checkbox"/> Speech Impairment	<input type="checkbox"/> Obesity	

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

Date of Lab Findings (dd/mm/yyyy)	FBG	★ A1C	LDL	eGFR	ACR
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★ **Current Medications** Please provide (name/dose/frequency) **List attached**

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)

Refer the patient to an Endocrinologist *First Available* *Specific, Name:* _____

Signature: _____ Billing #: _____

★ **INDICATES INFORMATION REQUIRED TO PROCESS REFERRAL**

Guidelines for Referral

URGENT

- Uncontrolled Diabetes
 - BG > 20mmol/L
 - Ketonuria > 1.5mmol/L
 - A1c >13%
- Recent Treatment For:
 - Diabetic ketoacidosis
 - Severe hypoglycemia
 - Nonketotic hyperosmolar hyperglycemia
- Newly Diagnosed Type 1
- Inpatient / Emergency Admission Follow-up
- Steroid Induced (escalating blood sugars)
- Pediatric (≤ 18 yr)

SEMI-URGENT

- A1c 11-13%
- Pregnancy with Pre-existing DM
- Gestational DM
- Steroid Induced (new diagnosis)

NON- URGENT

- Pre-Diabetes
- Type 2
- Insulin Pump
- Type 2 insulin initiation
- Type 1 Follow-up

CENTRE FOR COMPLEX DIABETES CARE (CCDC)

- Pre existing & uncontrolled diabetes (A1C>9%) **AND** 1 or more conditions that negatively impact glycemic control
- Recurrent ER visits or hospitalizations for DKA, severe hypoglycemia, or non-ketotic hyperosmolar hyperglycemia
- Complex medical and/or psychosocial conditions that negatively impact diabetes self-care regardless of A1C (e.g. renal failure/dialysis, CHF, malignancy, COPD, severe persistent mental health or cognitive concerns, financial stress, difficulty accessing care)
- Non-healing diabetic ulcer/wound (or at high risk of developing)

Patients who do not meet the referral criteria will automatically be referred to the local Diabetes Education Program

INSULIN ORDERS

- Complete and attach Canadian Diabetes Association Insulin Prescription Form for insulin initiation orders
- Obtain CDA Insulin Prescription form: www.guidelines.diabetes.ca

Diabetes Services in Mississauga-Halton Region

	Credit Valley FHT	Diabetes Management Centre (Mississauga Hospital)	Halton Diabetes Program (Oakville, Milton, Georgetown, Burlington)	LMC Diabetes & Endocrinology	East Mississauga CHC	Centre for Complex Care (Halton, Mississauga)
Type 1		•	•	•		•
Type 2	•	•	•	•	•	•
Pre-Diabetes	•	•	•	•	•	
Pediatric Transition Program		•				
Diabetes in Pregnancy		•	•			
Lifestyle	•	•	•	•	•	•
Oral Agents	•	•	•	•	•	•
Insulin	•	•	•	•	•	•
Insulin Pump		•	•	•		•
Inter-Disciplinary Team		•	•	•	•	•
Endocrinologist on-site		•	•	•		
Extended Hours	•	•	•		•	•
French	•					
Other Languages		•	•	•	•	•

Mississauga-Halton Central Intake Program

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