Transfer of Care Form
Pediatric Diabetes Services

Fax: (905) 338-0442
Phone: (905) 338-2983
www.mhcentralintake.com

Patient Information

Last name: First name: Gender:

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

Address: Postal Code:

Interpreter Required? For Parents □ Yes □ No For Child □ Yes □ No

Communication Barrier: □ Yes □ No If yes, please specify:_____

Parent / Guardian Information

1. Name: 2. Name:

Phone: Phone:

Email: Email:

Custody Status

Who does the patient reside with? □ Both parents □ Mother □ Father □ Guardian(s)

Custody: □ Mother □ Father □ Joint □ Other:_____ CAS/FACS Involvement? □ Yes □ No

Reason for Referral - Pediatric DEP transfer of Care **□ Attach Consult Notes**

Diabetes Diagnosis		**Duration of Diabetes**	
□ Type 1	□ Monogenic Diabetes	□ Newly diagnosed	Date of Diagnosis: ____/____/_____
□ Type 2	□ Unsure	□ 5-10 years	□ >10 years

Current Treatment □ MDI □ Pump

Diabetes History Hx of DKA since diagnosis? □ Yes □ No Unconscious hypoglycemia? □ Yes □ No

Diabetes Education - ***please attach relevant documents***

Has had previous Diabetes education: □ Yes □ No When: Where:

Last seen: Next appointment:

Other Diagnoses □ Celiac □ Thyroid □ Other:_____

Other Medications *Please provide (name/dose/frequency)* **□ List attached**

Additional Information

Current Height: Weight: Date: Recent A1C: Date:

Additional useful information to include if available: □ Other relevant blood work (e.g. TSH, anti-TPO Ab, anti-tTG, Lipids, OGTT)
□ Consult notes, diabetes education checklist

HOSPITAL USE ONLY: Is this patient being discharged from Hospital? □ Yes □ No
Hospital Name _____ □ Inpatient □ ED

Family Physician *(if different than below)* Name: Phone: Fax:

Referring Provider Name: □ MD □ NP □ Other _____

Billing #:	Address:
Signature:	Phone:
Referral Date:	Fax:

Mississauga Halton Central Intake Program

Halton Healthcare
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03/2020

Guidelines for Referral

Pediatric Diabetes Programs in Mississauga-Halton LHIN

	Trillium Health Partners	Halton Healthcare
Type 1	●	●
Type 2	●	●
Age Requirement	no minimum age	Greater than 5 years of age
Oral Agents	●	●
Insulin	●	●
Pediatric Endocrinologist Consultation	●	●
Social Worker	●	●
Child life specialist	●	
Insulin Pumps	●	●
Continuous Glucose Monitoring	●	●
Pediatric transition	●	●
Extended hours		●
Other Languages	●	●

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

03/2020