Trillium Health Partners

PAEDIATRIC DIABETIC MANAGEMENT CENTRE
REFERRAL FORM
P: 905-813-1576 F: 905-813-4128

REASON FOR CONSULT:

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Address:			
City:		**Postal Code:**	
H:	( )	**M (child):**	( )
M (mother):	( )	**M (father):**	( )
Email:			
Primary: Language		☐ Interpreter Needed	

NEWLY DIAGNOSED WITH DIABETES?
☐ YES ☐ NO, Diagnosis (MM/YY):______________

PREVIOUS DIABETES EDUCATION:
DATE (dd/mm/yyyy):__________ Physician:______________ Program/Hospital:______________

OTHER MEDICAL CONDITIONS AND PREVIOUS HOSPITALIZATION:

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MEDICATIONS:

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____

ALLERGIES:

____

Weight: __________ **Height:** __________ **DATE** (dd/mm/yyyy): __________

LABORATORY RESULTS: ☐ SEE ATTACHED BLOOD WORK
Date: ______________ HgbA1C______________
Date: ______________ Insulin dose administered (new onset):______________
Date: ______________ Other: ______________

IS THIS PATIENT BEING DISCHARGED FROM A HOSPITAL? ☐ NO ☐ YES ⇨ ☐ Inpatient ☐ Emergency
Hospital Site: ☐ CVH ☐ MH ☐ HHS ☐ SICKKIDS OTHER: __________

Family MD: ______________ ☐ Client doesn't have a Primary Care Physician
Referring MD: ______________ PHONE: ______________
OHIP Billing #:______________

Physician's Signature: ______________ DATE (dd/mm/yyy): ______________

Please include all relevant consultation notes, copies of recent laboratory data, growth chart, Rourke Child Record and hospital discharge summary. Appointments will not be booked until all required information has been provided. Please note, while patients are awaiting paediatric diabetes consultation, Paediatric Diabetes Management Centre cannot accept responsibility for their health care until the patient has been seen. As their referring professional, you remain responsible for all their medical related care.

THANK YOU FOR YOUR REFERRAL, WE WILL CONTACT THE PATIENT WITH THE APPOINTMENT TIME AND LOCATION INFORMATION. PLEASE ENSURE THE CONTACT INFORMATION IS CURRENT

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