

# Referral Form

## Diabetes Services

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

**★Patient Information** *Patients must be 18 years of age or older*

Last name: \_\_\_\_\_ First name: \_\_\_\_\_  Male  Female  
 DOB(dd/mm/yyyy): \_\_\_\_\_ OHIP#: \_\_\_\_\_ Preferred language: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

**Priority** (See reverse for Guidelines)  **Urgent**  **Semi-Urgent**  **Non-Urgent**

Reason For Referral:

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

Patient Preferred Program (see reverse for list):

*For Self Management resources visit [www.maximizeyourhealth.ca](http://www.maximizeyourhealth.ca)*

<b>★Diabetes Diagnosis</b>	<b>Duration In Years</b> <input type="checkbox"/> New <input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 10+
<input type="checkbox"/> Type 1 <input type="checkbox"/> Steroid-Induced	<b>Diabetes in Pregnancy</b> <b>Please attach blood work</b> <b>★EDC: (dd/mm/yyyy)</b>
<input type="checkbox"/> Type 2 <input type="checkbox"/> Pre-diabetes	<input type="checkbox"/> Newly Diagnosed GDM <input type="checkbox"/> Repeat GDM
	<input type="checkbox"/> Pre-existing Pre-Diabetes <input type="checkbox"/> Pre-existing Type 2 <input type="checkbox"/> Pre-existing Type 1
	<b>★Delivery Hospital: THP:</b> <input type="checkbox"/> CVH <input type="checkbox"/> MH <b>HHS:</b> <input type="checkbox"/> GH <input type="checkbox"/> MDH <input type="checkbox"/> OTMH

**Medical History**

<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"/> Mental Illness	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Smoker	<input type="checkbox"/> Speech Impairment	<input type="checkbox"/> Obesity	<input type="checkbox"/> Mobility Impairment	

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

Date of Lab (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, Hospital Name \_\_\_\_\_  Inpatient  ED

Is the patient currently seeing an endocrinologist (visit within last 12 months)?

No  Yes, Name: \_\_\_\_\_

**I hereby authorize the following:**

- Patients may receive consult with an affiliated endocrinologist as appropriate (see reverse for criteria)
- Point of Care testing (blood/ketone) to be performed by a diabetes educator

**Primary Care Provider:** \_\_\_\_\_  **Patient does NOT have a PCP**

**★Referring Provider Name :** \_\_\_\_\_  MD  NP  Other \_\_\_\_\_

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

**★ MANDATORY INFORMATION**



Mississauga Halton  
Central Intake Program



11/2019

# Guidelines for Referral

## Priority

### *Urgent*

- |   |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li>• Uncontrolled Diabetes                             <ul style="list-style-type: none"> <li>– BG &gt; 20mmol/L</li> <li>– Ketonuria &gt; 2.0 mmol/L</li> <li>– A1C &gt;13%</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>• Recent Treatment For:                             <ul style="list-style-type: none"> <li>– Diabetic ketoacidosis</li> <li>– Severe / repeat hypoglycemia</li> <li>– Nonketotic hyperosmolar hyperglycemia</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>• Newly Diagnosed Type 1</li> <li>• Inpatient / Emergency Admission Follow-up with unstable blood glucose patterns</li> <li>• Glucocorticoid induced hyperglycemia</li> </ul> |
|---|---|--|

### *Semi-Urgent*

- A1C 11-13%
- Pregnancy with Pre-existing DM
- Gestational DM
- Steroid Induced DM

### *Non-Urgent*

- Pre-Diabetes
- Type 2 (newly diagnosed, insulin initiation & management)
- Insulin Pump
- Type 1 Follow-up

## Endocrinology Consult Criteria

The Diabetes Programs may utilize the following criteria to facilitate consult with their affiliated endocrinologist as part of the patient's diabetes management plan:

- Type 1 Diabetes, diagnosis clarification, pediatric transition
- Inpatient/ER discharge for unstable blood glucose pattern, DKA, HHS
- Glucocorticoid induced hyperglycemia
- Type 2 Diabetes - uncontrolled diabetes despite treatment, A1C>11%, and/or repeated hypoglycemia events
- Diabetes in pregnancy and pre-conception counselling

## Insulin Initiation Orders

- Complete and attach Diabetes Canada Insulin Prescription Form for insulin initiation orders
- Obtain Insulin Prescription form: [www.mhcentralintake.com](http://www.mhcentralintake.com)

## Diabetes Programs in Mississauga-Halton LHIN

	Credit Valley FHT	Diabetes Management Centre	Halton Diabetes Program	West Toronto Diabetes Program	Centre for Complex Diabetes Care	LMC Diabetes & Endocrinology
Type 1		•	•		•	•
Type 2	•	•	•	•	•	•
Lifestyle Management	•	•	•	•	•	•
Oral Agents	•	•	•	•	•	•
Insulin	•	•	•	•	•	•
Diabetes in Pregnancy		•	•			
Endocrinologist on site		•	•		•	•
Social worker		•	•		•	
Kinesiologist		•	•		•	
Prediabetes	•	•	•	•		•
Insulin pump/CGM		•	•		•	•
Pediatric transition		•	•			•
French team	•					
Extended hours	•	•	•	•	•	
Other Language	•	•	•	•	•	

## Mississauga-Halton Central Intake Program

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To submit referrals online visit [www.mhcentralintake.com/eReferral](http://www.mhcentralintake.com/eReferral)