Print Clear Form

Providence HEALTH CARE

ST. PAUL'S HOSPITAL
DIABETES HEALTH CENTRE
REFERRAL

Place Patient Form Label Here

* 3 9 3 4 *

Endocrinology Referral

FAX # 604-806-8572

Complete ALL SECTIONS or referral will be returned.

Appointment Date: _____
(To be completed by Clerk at the Diabetes Centre)

Please print clearly.

Last name: _____ First name: _____

Date of birth: (dd/mmm/yyyy) _____ PHN No: _____

Mailing address: _____

City: _____ Province: _____ Postal Code: _____

Preferred phone #: _____ Email address: _____

Referring MD

Printed name: _____ **Signature:** _____ **MSP No.** _____

Phone number: _____ **Fax number:** _____

Reason for Referral

☐ Pre Diabetes (IFG/IGT) ☐ Type1 ☐ Type 2 Age at diagnosis: _____

☐ Insulin pump ☐ Other: _____

PATIENT'S LANGUAGE: ☐ English ☐ Other: (specify) _____ ☐ Patient will bring interpreter ☐ Book interpreter

Diabetes medications/dose: _____

Additional medications/dose: _____

Related Medical Issues:

☐ Heart Disease ☐ Dyslipidemia ☐ Hypertension ☐ Nephropathy ☐ Retinopathy ☐ Neuropathy

☐ Depression ☐ Other: _____

LAB WORK

PLEASE FAX RECENT (within the last month) **LAB VALUES TO THE DIABETES CENTRE**

Fasting glucose, A1C, total cholesterol, LDL, HDL, Triglycerides, total/HDL ratio, eGFR, microalbumin/creatinine ratio

FAX # 604-806-8572. If you have any questions please call 604-806-8357.

Endocrinology Referral: ☐ **Yes** ☐ **No**

Please note: The patient will be seen by one of our endocrinologists if one of the following is present:

a) A1c above 10%

b) A1c remains above 8% at 6 months after completing our education program

FAX completed Referral and lab results to the Diabetes Health Centre - 604-806-8572