



Central/North Island Diabetes Education Centre Referral

Please Fax Completed Referral to:

- | | |
|--|--|
| <input type="checkbox"/> Campbell River Diabetes Centre (250) 850-2618 | <input type="checkbox"/> Nanaimo Diabetes Centre (250) 716-7711 |
| <input type="checkbox"/> Comox Valley Diabetes Centre (250) 339-1439 | <input type="checkbox"/> Parksville Diabetes Centre (250) 947-8216 |
| <input type="checkbox"/> Cowichan/Ladysmith Diabetes Centre (250) 709-3065 | <input type="checkbox"/> Port Alberni Diabetes Centre (250) 724-8848 |
| <input type="checkbox"/> Mt. Waddington Diabetes Centre (250) 956-3653 | <input type="checkbox"/> Tofino Diabetes Centre (250) 724-8848 |

Name: _____	Date of Birth: _____
Address: _____	
Postal Code: _____	Phone: (H): _____ (W): _____
Physician: _____	PHN #: _____

New Diagnosis: Yes No

Please complete in full or attach these recent lab results

Insulin Start:

Starting dose: _____

Insulin	Breakfast	Lunch	Dinner	HS

Adjust _____ Insulin by _____ units q _____ days

Type 1: Insulin Routine: _____

Type 2 **Pre-Diabetes**

Current therapy:

- Diet only
- Oral Agents: _____

Insulin: _____

Gestational Diabetes: EDC: _____

*Please attach labs and prenatal record.

Other medications: _____

Comments/ other health concerns: _____

Physician's Signature: _____

Administration Use

Date Received: _____	Date Contacted: _____
Booking Info: _____	

Lab Work

Attached Date: _____

- FBS: _____
- 2 hr pc: _____
- A1C: _____
- ACR: _____

Date: _____

- Triglycerides: _____
- Total Chol: _____
- HDL: _____
- LDL: _____
- Ratio TC:HDL: _____

Barriers to learning:

<input type="checkbox"/> Hearing	<input type="checkbox"/> Vision
<input type="checkbox"/> Language	<input type="checkbox"/> Other