Diabetes Care Services-Self Referral Form

Name:_________________ Address:____________________________

Health Card Number:__________________ Family Physician__________________

Telephone number:___________________

First Language: ☐English ☐French ☐Other _____

How long have you had diabetes or high blood sugar?_________________________________

Have you had diabetes education in the past? ☐Yes ☐No

How is your diabetes treated: ☐Diet only ☐Diet & Pills ☐Diet & Insulin ☐Diet, Pills & Insulin

Have you been hospitalized for your diabetes in the past year? ☐Yes ☐No
When:__________________ **Where:**______________________

Are you being treated for any of the following?

☐High Blood Pressure ☐Eye Disease ☐High Cholesterol/Triglycerides ☐Kidney Disease

☐Other

Type of Diabetes: ☐Impaired Glucose Tolerance ☐Impaired Fasting Glucose ☐Secondary Diabetes

☐Type 1 ☐Type 2 ☐Gestational Diabetes ☐Other______________________

This program offers individual appointments with Registered Nurses, Registered Dietitians, Social Workers and Group Classes. What interest you?______________________________

________________________________ ________________________________

Signature *Date Completed*