Providence HEALTH CARE

St. Paul's Hospital

DIABETES HEALTH CENTRE REFERRAL
FAX # 604-806-8572

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

PLEASE PRINT CLEARLY

Last name: _____ First name: _____

Date of birth: (dd-mon-yyyy) _____ PHN No: _____

Mailing address: _____

City: _____ Province: _____ Postal Code: _____

Home phone number: _____ Daytime contact number: _____

Referring MD

Printed name: _____ Signature: _____ MSP No._____

Phone number: _____ Fax number: _____

Non English speaking patients are required to bring an interpreter to their appointments.

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.

Reason for Referral

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

☐ Insulin pump ☐ Other: _____

Diabetes medications/dose: _____

Additional medications/dose: _____

Related Medical Issues:

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

☐ Depression ☐ Other: _____

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

Your referral will be acknowledged within 3 days.
Our office will make an appointment with your patient within the next 2 weeks.