

Referral Form

Diabetes Services

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

★Patient Information <i>Patients must be 18 years of age or older</i>							
Last name:		First name:			<input type="checkbox"/> Male <input type="checkbox"/> Female		
DOB(dd/mm/yyyy):		OHIP#:		Preferred language:			
Phone:		Email:					
Address:		Postal Code:					
Priority (See reverse for Guidelines) <input type="checkbox"/> Urgent <input type="checkbox"/> Semi-Urgent <input type="checkbox"/> Non-Urgent							
Reason For Referral:							
<input type="checkbox"/> Insulin Initiation by RN and/or RD (Must be accompanied by completed Insulin prescription form)							
Patient Preferred Program (see reverse for list):							
<i>Refer to Chronic Disease Self Management Program (Maximize Your Health)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No							
★Diabetes Diagnosis				Duration In Years <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		<input type="checkbox"/> Type 2 <input type="checkbox"/> Pre-diabetes		Diabetes in Pregnancy		Please attach blood work ★EDC: (dd/mm/yyyy)	
				<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			
				★Delivery Hospital: THP: <input type="checkbox"/> CVH <input type="checkbox"/> MH HHS: <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 <input type="checkbox"/> Lab Results Attached							
Date of Lab (dd/mm/yyyy)		FBG	★A1C	LDL	eGFR	ACR	
★Current Medications Please provide (name/dose/frequency) <input type="checkbox"/> List attached <input type="checkbox"/> No Diabetes Medications							
HOSPITAL USE ONLY: IS THIS PATIENT BEING DISCHARGED FROM A HOSPITAL?							
<input type="checkbox"/> No <input type="checkbox"/> Yes, Hospital Name _____ <input type="checkbox"/> Inpatient <input type="checkbox"/> ED							
Is the patient currently seeing an endocrinologist (visit within last 12 months)?							
<input type="checkbox"/> No <input type="checkbox"/> 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:				<input type="checkbox"/> Patient does NOT have a PCP			
★Referring Provider Name :				<input type="checkbox"/> MD <input type="checkbox"/> NP <input type="checkbox"/> 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"> • Uncontrolled Diabetes <ul style="list-style-type: none"> – BG > 20mmol/L – Ketonuria > 2.0 mmol/L – A1C >13% | <ul style="list-style-type: none"> • Recent Treatment For: <ul style="list-style-type: none"> – Diabetic ketoacidosis – Severe / repeat hypoglycemia – Nonketotic hyperosmolar hyperglycemia | <ul style="list-style-type: none"> • Newly Diagnosed Type 1 • Inpatient / Emergency Admission Follow-up with unstable blood glucose patterns • Glucocorticoid induced hyperglycemia |
|---|---|--|

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

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