fhc
FLEMINGDON
HEALTH CENTRE

Don Mills Diabetes Education Program

PROVIDER REFERRAL FORM

Ontario's Community Health Centres

Patient Name: ______________________________________ Date of Birth: _____________________

Address: ____

Telephone Number: __________________________ Preferred Language: ______________________

Patient Diagnosis:
- □ **Type 2 Diabetes**
- □ **Pre-diabetes**

Provided Services:
Individual/ group **(**3-or 4-day sessions) education sessions including: Nutrition Counselling, Self-Monitoring of Blood Glucose (SMBG), Self-management support

□ **Initiate/ titrate/ dispense insulin: please complete, sign and fax the Insulin Order Form (See page 2)**

Type of Medication/Insulin	Dosage	Frequency	Follow-up instructions:

Laboratory values: Please write below, or attach the latest results

FBG:	HDL:	TG:	Micro Albumin:
A1C:	LDL:	TC/HDL:	Others:

Please specify the A1C target for this patient: _________%

<6.5	Adults with T2DM to reduce complications if at low risk of hypoglycemia	**7.1 --- 8.5**	Functionally dependent: 7.1- 8.0% Recurrent severe hypoglycemia/ hypo unawareness or Limited life expectancy or Frail elderly and/or with dementia: 7.1- 8.5 %
<7.0	Most adults with T1 or T2 diabetes		

Ref: Diabetes Canada Guidelines 2018

Other relevant medical conditions:

____

____

Referring Provider: ____________________________________ Date: _____________________

Address: _________________________________ Tel.: ________________ Fax: ________________

10 Gateway Blvd
Toronto, ON M3C 3A1
Tel # 416.429.4991 x 276
Fax # 416.422.4124

5 Fairview Mall Drive
Suite 359
Toronto, ON M2J 2Z1
Tel # 416.640.5298 x 216
Fax # 416.642.2238

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INSULIN START / TITRATION / DISPENSING ORDER

Ontario's Community Health Centres

Patient Name: ___________________________________ Date of Birth: _____________________

Kindly complete if you would like insulin titration and/or dispensing support:

	Insulin Type	Starting Dose	Titration Instructions
Basal	☐ Tresiba U-100 ☐ Lantus ☐ Tresiba U-200 ☐ Basaglar ☐ Toujeo SoloSTAR ☐ Levemir ☐ Toujeo DoubleSTAR ☐ Humulin N ☐ Novolin ge NPH	____ units at ☐ am ☐ pm	Increase dose by ______ units every ______ day(s) until fasting blood glucose has reached the target of ______ to ______ mmol/L.
Fixed-Ratio Combination	☐ Xultophy ☐ Soliqua	____ units at ☐ am ☐ pm	Increase dose by ______ units every ______ day(s) until fasting blood glucose has reached the target of ______ to ______ mmol/L
Bolus	☐ Humalog U-100 ☐ Fiasp ☐ Humalog U-200 ☐ Novolin ge Toronto ☐ NovoRapid ☐ Humulin R ☐ Apidra ☐ Admelog	____ units at acB ____ units at acL ____ units at acD	Increase dose by ______ units every ______ day(s) until pre-meal blood glucose has reached the target of ______ to ______ mmol/L.
Mixed	☐ Humalog Mix25 ☐ Novolin ge 30/70 ☐ Humalog Mix50 ☐ Novolin ge 40/60 ☐ NovoMix 30 ☐ Novolin ge 50/50 ☐ Humulin 30/70	____ units at am meal ____ units at pm meal	Increase dose by ______ units every ______ day(s) until pre-meal blood glucose has reached the target of ______ to ______ mmol/L.

DM DEP RN and RD can dispense samples of the medications selected above: ☐ Yes ☐ No
(Subcutaneous GLP-1 RA medications can also be dispensed with attached prescription).

Oral Diabetes Medications:

Continue: ____

Discontinue: ____

Provider Signature: ________________________________ Date: ___________________________

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