

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: \_\_\_\_\_%**

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

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**

**Don Mills Diabetes Education Program**  
**INSULIN START / TITRATION / DISPENSING ORDER**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

	Insulin Type	Starting Dose	Titration Instructions
<b>Basal</b>	<input type="checkbox"/> Tresiba U-100 <input type="checkbox"/> Lantus <input type="checkbox"/> Tresiba U-200 <input type="checkbox"/> Basaglar <input type="checkbox"/> Toujeo SoloSTAR <input type="checkbox"/> Levemir <input type="checkbox"/> Toujeo DoubleSTAR <input type="checkbox"/> Semglee <input type="checkbox"/> Novolin ge NPH <input type="checkbox"/> Humulin N	_____ units at <input type="checkbox"/> am <input type="checkbox"/> pm	Increase dose by _____ units every _____ day(s) until fasting blood glucose has reached the target of _____ to _____ mmol/L.
<b>Fixed-Ratio Combination</b>	<input type="checkbox"/> Xultophy <input type="checkbox"/> Soliqua	_____ units at <input type="checkbox"/> am <input type="checkbox"/> pm	Increase dose by _____ units every _____ day(s) until fasting blood glucose has reached the target of _____ to _____ mmol/L
<b>Bolus</b>	<input type="checkbox"/> Humalog U-100 <input type="checkbox"/> Fiasp <input type="checkbox"/> Humalog U-200 <input type="checkbox"/> Novolin ge Toronto <input type="checkbox"/> NovoRapid <input type="checkbox"/> Humulin R <input type="checkbox"/> Apidra <input type="checkbox"/> Admelog <input type="checkbox"/> Trurapi	_____ 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.
<b>Mixed</b>	<input type="checkbox"/> Humalog Mix25 <input type="checkbox"/> Novolin ge 30/70 <input type="checkbox"/> Humalog Mix50 <input type="checkbox"/> Novolin ge 40/60 <input type="checkbox"/> NovoMix 30 <input type="checkbox"/> Novolin ge 50/50 <input type="checkbox"/> 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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