

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%
<7.0	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 416
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
Basal	<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"/> Awiqli <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.
Fixed-Ratio Combination	<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.
Bolus	<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 <input type="checkbox"/> Kirsty	_____ 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	<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

Oral Diabetes Medications:

Continue: _____

Discontinue: _____

Provider Signature: _____ Date: _____

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