



Interior Health

Royal Inland Hospital

Diabetes Education Program Physician Referral

Adult Program Pediatric Program

Name: _____ Parents (if applicable): _____

Address: _____ Postal Code: _____

Birthdate: _____ PHN: _____ Home Telephone # _____

Family Physician: _____ Work Telephone # _____

Reasons for Referral: _____

Date of Onset of Diabetes: _____ Is this an urgent referral? Yes No

Type of Diabetes: Type 1 Impaired Glucose Tolerance
 Type 2 Gestational Diabetes
 Impaired Fasting Glucose Pregnancy & Diabetes

Activity Contraindications: Yes - Describe _____ No

If no, do you consent to your patient participating in the **TCC Diabetes/Exercise Class**?

Yes No (Criteria: Patients with Pre-diabetes or Type 2 diabetes currently managed with lifestyle or Metformin only)

Medical History: Hypertension Nephropathy
 Retinopathy Cardiovascular Disease
 Neuropathy Other:

Request Physician/Team Consult

Required Labwork:	Date:	Date:
FBS _____ 2 hr. p.c. _____	_____	Cholesterol _____
Random Blood Sugar _____	_____	LDL _____
Glycosylated Hemoglobin _____	_____	HDL _____
Microalbumin/Creatine ratio _____	_____	Triglycerides _____
eGFR _____	_____	Chol/HDL ratio _____

Note: If lab results are not available, lab tests will be ordered by Diabetes Education Program

Medications:

Insulin Type: _____ Dose: _____
 _____ Dose: _____

Insulin Pump Correction Scale: _____

Oral Hypoglycemic Agents: Metformin _____ Dose: _____
 Secretagogue _____ Dose: _____
 Other _____ Dose: _____

Other Medications: _____

Insulin Start Insulin Type & Dose _____

Titrate to Target Yes No

Barriers to Learning: Physical Challenge Mental Challenge Literacy Language Other

Additional Comments: _____

Physician's Signature: _____ Date: _____

Mail completed form to Royal Inland Hospital, Diabetes Education Program, 311 Columbia St, Kamloops, BC V2C 2T1 or Fax to 250-314-2198