St. Michael's

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# Diabetes Clinic Referral Form Fax to 416.867.3654

Centre for Diabetes and Endocrinology
St. Michael's Hospital
61 Queen Street East, 7th floor
Toronto, ON M5C 2T2
Booking office: 416-867-3679

Reset Form | Print

**Patient ID**

**Office use only:** ☐ Emergent ☐ Urgent ☐ Routine

Patient Name: _____ DOB: _____
*first* *last* *dd/mmm/yyyy*

Address: _____ _____ _____
*street number* *street name* *unit*

_____ _____ _____
*City* *postal code* *Tel: home/cell*

Health Card: _____ Version Code: _____ Gender: ☐ Male ☐ Female ☐ Unknown

Patient Email: _____ Patient consent for email: Y/N _____

| | |
|---|---|
| Type of Diabetes: | ☐ Type 1 ☐ Type 2 ☐ Not Known ☐ Other: |
| Most Recent A1C (within 3 months) _____ % | Date: _____ |
| Insulin: | ☐ None ☐ Insulin Pump ☐ MDI ☐ Mixed ☐ Basal Only |
| Non-Insulin Anti-Hyperglycemics | ☐ None ☐ Single Agent ☐ Two agents ☐ Three or more agents |
| Specific Consultation request: | |
| Type of Consultation request: | ☐ Consult Only (Follow up by referring doctor)<br>☐ Shared Care (Consultation and ongoing diabetes management) |

Urgent: ☐ Yes ☐ No

*If urgent, please make patient aware that they will receive their appointment time/date via telephone within 7 days. Please ask them to contact us directly, if they do not hear from us in this time period (or do not have a working phone). They should expect their appointment to be within 3 weeks of referral date (and we will be unable to accommodate an appointment after this time period).*

if yes, must indicate why:

- ☐ New Diagnosis of Type 1
- ☐ Systemic steroid initiation/titration with poor glycemic control
- ☐ Symptomatic hyperglycemia/metabolic decompensation
- ☐ Open wound with poor glycemic control (also refer to wound clinic)
- ☐ Hypoglycemia that is severe, recurrent or unawareness
- ☐ Recurrent admission for DKA
- ☐ Other: _____

**Please attach cumulative patient profile (medical problem list, medication list) and recent laboratory tests.**

Name: _____ Signature: _____

Address: _____ Date: _____

Telephone: (  ) _____ Fax: (  ) _____ Billing #: _____

Please note that the Diabetes Clinic does not accept referrals for:
Pregnant or pre-conception counseling: fax referral directly to the Diabetes in Pregnancy Clinic FAX: 416-867-3742
Pre-Diabetes: refer to local DEP via **http://torontodiabetesreferral.com/online**

***Please note that patients referred to the diabetes clinic will be seen by the next available physician.***

*Form No. 73802 Rev. Feb.13_2018*