Thunder Bay Regional Health Sciences Centre

CENTRE FOR COMPLEX DIABETES CARE (CCDC)

OUTPATIENT REFERRAL FORM

Patient Name: _____

D.O.B. (YYYY-MM-DD): _____

Address: _____

City/Town, Prov: _____

Postal Code: _____ Tel: _____

Health Card #: _____ Version: ____

Place Patient Label with Barcode Here

Contact the CCDC clinic at 807-684-6944 if you have any questions regarding the completion of this form. (CCDC not open on weekends)

Guidelines:

1) Form to be completed by physician/nurse practitioner
2) Please completed form in entirety and/or attach required information. **Incomplete referrals will not be accepted.**
3) Please ensure blood work within 3 months of referral date attached
4) **Triage time 72 hours to 1 week. Please ensure patient is provided with prescription for Blood Glucose Meter prescription, test strips, lancets and/or medication initiated as indicated**
5) Fax completed form to the CCDC at 807-684-5928
6) Form to be maintained as part of the patient's medical legal record.
7) Referrals for inpatients should be entered in Meditech Order Entry. Form should only be used for inpatients in the event of a Meditech Downtime

Diagnosis:

□ New Type 1 Diabetes □ New Type 2 Diabetes □ Existing Type 1 Diabetes □ Existing Type 2 Diabetes

Medical History:

□ Cardiovascular Disease □ Dyslipidemia
□ Hypertension □ Nephropathy
□ Retinopathy □ Neuropathy
□ Mental Health □ Overweight/Obesity
□ Thyroid □ Drug/Alcohol Abuse
□ Complicated Wounds

□ Other(specify):

Antihyperglycemics (list and/or attach):

_____

_____

_____

Recent Lab results (within last 3 months):

□ **Attached**

- HA1C
- eGfr
- Lipids
- Urine ACR

Challenges/barriers: (check all that apply)

□ Remote community □ Finance □ Drug/alcohol use □ Mobility issues
□ Developmental □ Visual impairment □ Hearing impairment □ Physical impairment
□ Language barriers □ Mental Health
□ Other (specify): _____

Specific Referral Issues:

□ Persistent Hyperglycemia □ Steroid Induced Hyperglycemia
□ Recurrent Hypoglycemia □ Severe Hypoglycemia (requiring ER)
□ Recurrent hospital admissions □ Recurrent ER visits
□ Medication assessment □ Psychosocial

_____

_____

_____

_____

Date: _____ **Referring Physician/Nurse Practitioner:** _____

(Sign/print)

TCCDCOUTPTREF