Self Referral Form

Diabetes Care & Research Program
1200 Main St W, Hamilton, On L8N 3Z5 Fax: 905 521 2653

Date:_____

Name_____ DOB:_____
first name *last name* *mm/dd/yyyy*

OHIP #_____ Phone number: _____
version code

Address_____
street *city/town* *postal code*

Reason for Referral:

◯ Type 1 Diabetes ◯ Type 2 Diabetes ◯ GDM ◯ At-Risk Diabetes ◯ Pre-diabetes

If you have diabetes or prediabetes, when were you diagnosed?

◯ Less than 6 months ◯ Greater than 6 months

How do you manage your diabetes?

◯ Lifestyle ◯ Oral Medication ◯ Insulin ◯ Other

If possible, please attach a copy of your medication list with referral form*

Recent Medical History (*check all that apply*):

◯ Family History of Diabetes ◯ High Blood Pressure ◯ High Cholesterol
◯ Diabetes while Pregnant ◯ Neuropathy (pain/numbness) ◯ Chronic Pain
◯ Nephropathy (kidney problems) ◯ Retinopathy (eye complications) ◯ Overweight/Obesity
◯ Other:_____

Do you have a Family Physician? ◯ Yes *(See Below)* ◯ No

Family Physician Contact Information:

Name:_____ Ph. #:_____

Fax #:_____

I authorize the staff from the *HHS Diabetes Care & Research Program* to contact my Family Physician to obtain more information, if required. ◯ Yes ◯ No

Areas of Interest within the Diabetes Clinic (*Check all that apply*):

◯ Medication Management & Diabetes Complications
◯ Positive Lifestyle & Behaviour Changes
◯ Individual Questions/Concerns about your Diabetes
◯ Diabetes and Exercise during Pregnancy
◯ Increase your Physical Activity Level
◯ Healthy Food Choices & Nutrition Advice
◯ Group Classes

For more information please call the Clinic at 905 521 2100 ext. 76061