



# Referral Form

## Diabetes Services

Fax: (905) 338-0442  
Phone: (905) 338-2983  
www.mhcentralintake.com

<b>★Patient Information</b> <i>Patients must be 18 years of age or older</i>							
Last name:		First name:		<input type="checkbox"/> Male <input type="checkbox"/> Female			
DOB(dd/mm/yyyy):		OHIP#:		Preferred language:			
Phone:				Email:			
Address:				Postal Code:			
<b>Priority</b> (See reverse for Guidelines) <input type="checkbox"/> <b>Urgent</b> <input type="checkbox"/> <b>Semi-Urgent</b> <input type="checkbox"/> <b>Non-Urgent</b>							
Reason For Referral:							
<input type="checkbox"/> Insulin Initiation by RN and/or RD (Must be accompanied by completed Insulin prescription form)							
Patient Preferred Program (see reverse for list):							
Refer to Chronic Disease Self Management Program (Maximize Your Health) <input type="checkbox"/> Yes <input type="checkbox"/> No							
<b>★Diabetes Diagnosis</b>		<b>Duration In Years</b> <input type="checkbox"/> New <input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 10+					
<input type="checkbox"/> Type 1 <input type="checkbox"/> Steroid-Induced <input type="checkbox"/> Type 2 <input type="checkbox"/> Pre-diabetes		<b>Diabetes in Pregnancy</b> <b>Please attach blood work</b> <b>★EDC:</b> (dd/mm/yyyy) <input type="checkbox"/> Newly Diagnosed GDM <input type="checkbox"/> Repeat GDM <input type="checkbox"/> Pre-existing Pre-Diabetes <input type="checkbox"/> Pre-existing Type 2 <input type="checkbox"/> Pre-existing Type 1 <b>★Delivery Hospital:</b> THP: <input type="checkbox"/> CVH <input type="checkbox"/> MH   HHS: <input type="checkbox"/> GH <input type="checkbox"/> MDH <input type="checkbox"/> OTMH					
<b>Medical History</b>							
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Dyslipidemia	<input type="checkbox"/> PVD	<input type="checkbox"/> CVD	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> CKD	<input type="checkbox"/> Retinopathy	<input type="checkbox"/> Other (Please Specify)
<input type="checkbox"/> Cognitive Impairment	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Smoker	<input type="checkbox"/> Speech Impairment	<input type="checkbox"/> Obesity	<input type="checkbox"/> Mobility Impairment	
<b>★Assessment Data</b> <input type="checkbox"/> Lab Results Attached							
Date of Lab (dd/mm/yyyy)		FBG	★A1C	LDL	eGFR	ACR	
<b>★Current Medications</b> Please provide (name/dose/frequency) <input type="checkbox"/> List attached <input type="checkbox"/> No Diabetes Medications							
<b>HOSPITAL USE ONLY: IS THIS PATIENT BEING DISCHARGED FROM A HOSPITAL?</b>							
<input type="checkbox"/> No <input type="checkbox"/> Yes, Hospital Name _____ <input type="checkbox"/> Inpatient <input type="checkbox"/> ED							
Is the patient currently seeing an endocrinologist (visit within last 12 months)?							
<input type="checkbox"/> No <input type="checkbox"/> Yes, Name: _____							
<b>I hereby authorize the following:</b> •Patients may receive consult with an affiliated endocrinologist as appropriate (see reverse for criteria ) • Point of Care testing (blood/ketone) to be performed by a diabetes educator							
Primary Care Provider:				<input type="checkbox"/> Patient does NOT have a PCP			
★Referring Provider Name :				<input type="checkbox"/> MD <input type="checkbox"/> NP <input type="checkbox"/> Other _____			
Billing #:				Phone:			
Signature:				Fax:			
Referral Date:				Address			
<div style="display: flex; justify-content: space-between; align-items: center;"> <div> <b>★</b>  <b>MANDATORY INFORMATION</b> </div> <div style="text-align: center;">  <p>Mississauga Halton Central Intake Program</p> </div> <div style="text-align: right;">  <p>Halton Healthcare GEORGETOWN • MILTON • OAKVILLE</p> </div> </div>							

# Guidelines for Referral

## Priority

### Urgent

- Uncontrolled Diabetes
  - BG > 20mmol/L
  - Ketonuria > 2.0 mmol/L
  - A1C >13%
- Recent Treatment For:
  - Diabetic ketoacidosis
  - Severe / repeat hypoglycemia
  - Nonketotic hyperosmolar hyperglycemia
- Newly Diagnosed Type 1
- Inpatient / Emergency Admission Follow-up with unstable blood glucose patterns
- Glucocorticoid induced hyperglycemia

### Semi-Urgent

- A1C 11-13%
- Pregnancy with Pre-existing DM
- Gestational DM
- Steroid Induced DM

### Non-Urgent

- Pre-Diabetes
- Type 2 (newly diagnosed, insulin initiation & management)
- Insulin Pump
- Type 1 Follow-up

## Endocrinology Consult Criteria

The Diabetes Programs may utilize the following criteria to facilitate consult with their affiliated endocrinologist as part of the patient's diabetes management plan:

- Type 1 Diabetes, diagnosis clarification, pediatric transition
- Inpatient/ER discharge for unstable blood glucose pattern, DKA, HHS
- Glucocorticoid induced hyperglycemia
- Type 2 Diabetes - uncontrolled diabetes despite treatment, A1C>11%, and/or repeated hypoglycemia events
- Diabetes in pregnancy and pre-conception counselling

## Insulin Initiation Orders

- Complete and attach Diabetes Canada Insulin Prescription Form for insulin initiation orders
- Obtain Insulin Prescription form: [www.mhcentralintake.com](http://www.mhcentralintake.com)

## Diabetes Programs in Mississauga-Halton LHIN

	Credit Valley FHT	Diabetes Management Centre	Halton Diabetes Program	West Toronto Diabetes Program	Centre for Complex Diabetes Care	LMC Diabetes & Endocrinology
Type 1		•	•		•	•
Type 2	•	•	•	•	•	•
Lifestyle Management	•	•	•	•	•	•
Oral Agents	•	•	•	•	•	•
Insulin	•	•	•	•	•	•
Diabetes in Pregnancy		•	•			
Endocrinologist on site		•	•		•	•
Social worker		•	•		•	
Kinesiologist		•	•		•	
Prediabetes	•	•	•	•		•
Insulin pump/CGM		•	•		•	•
Pediatric transition		•	•			•
French team	•					
Extended hours	•	•	•	•	•	
Other Language	•	•	•	•	•	

## Mississauga-Halton Central Intake Program

Phone: (905) 338-2983 Fax: 905-338-0442

To submit referrals online visit [www.mhcentralintake.com/eReferral](http://www.mhcentralintake.com/eReferral)