GROUP HEALTH CENTRE
ALGOMA DIABETES EDUCATION & CARE PROGRAM
83 Willow Avenue, Sault Ste. Marie, ON P6B 5B1
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Internet: www.ghc.on.ca/programs/content.html?sID=80

NDHN MEMBER PROGRAM

REFERRAL FORM DIETITIANS & NURSE EDUCATORS

☐ Newly Diagnosed ☐ Previously Instructed

Name: _____ Date of Birth: _____/_____/_____ (M D Y)

Address: _____ Postal Code: _____

Telephone: Home # _____ Work # _____

Health #: _____ Language: _____

Diagnosis: _____

Medical History: _____

Blood Values: 1. Fasting Blood Sugar _____ Date: _____/_____/_____ (M D Y)

2. Two Hour PC _____ Date: _____/_____/_____ (M D Y)

3. HbA1C _____ Date: _____/_____/_____ (M D Y)

4. Total Cholesterol _____ Date: _____/_____/_____ (M D Y)

5. LDL _____ Date: _____/_____/_____ (M D Y)

6. HDL _____ Date: _____/_____/_____ (M D Y)

7. Triglycerides _____ Date: _____/_____/_____ (M D Y)

8. Total Chol/HDL Ratio _____ Date: _____/_____/_____ (M D Y)

Height: _____ Weight: _____ Blood Pressure: _____

☐ Insulin: _____

☐ OHA: _____

Other Medications: _____

Exercise Restrictions? ☐ No ☐ Yes _____

Other Medical Concerns: _____

_____

Comments/Special Requests: _____

_____

Signature: _____ Phone #: _____

Date: _____/_____/_____ (M D Y)

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