



GROUP HEALTH CENTRE
ALGOMA DIABETES EDUCATION & CARE PROGRAM
 83 Willow Avenue, Sault Ste. Marie, ON P6B 5B1
 Telephone (705) 541-2670 • Fax (705) 942-9980 Internet: www.ghc.on.ca



DIABETES REFERRAL FORM

Name: _____

Date of Birth: ____/____/____
M D Y

Address: _____

Postal Code: _____

Telephone: Home # _____

Alternate # _____

Is this Patient Group appropriate? Yes No

Diagnosis: _____ New Diagnosis Previous Diabetes Education

Insulin: _____

OHA (diabetes medications): _____

Other Medications: _____

Other Medical Concerns: _____

BLOOD VALUES: Date: ____/____/____

Fasting Blood Sugar _____

LDL _____

HbA1C _____

HDL _____

Total Chol / HDL Ratio _____

Triglycerides _____

Comments/Special Instructions: _____

Authorization for: Insulin Dose Adjustment: Yes No Oral Dose Adjustment: Yes No
 Duration of Authorization: 1 month 4 months Other: _____

Date: ____/____/____
M D Y

Physician's Name: _____

Physician's Signature: _____