Alberta Health Services

Diabetes Program Referral - Adult

Please fax completed form to Central Access 780.735-3553. For inquiries call 780.401.2665

*Denotes Required Information

Please complete all patient demographic fields or affix Patient Label	
Name *(Last, First)*	
Gender ☐ Male ☐ Female	
Street Address	
City	Postal Code
Home phone	Alternate phone
Personal Health Number	Birthdate *(yyyy-Mon-dd)*

***Referring Physician/Nurse Practitioner** *(required)*		**Family Physician** *(if different than Referring Physician)*	
Name	Practice ID#	Name	Practice ID#
Phone Number	Fax	Phone Number	Fax
Diabetologist *(if applicable)*		**Obstetrician/Gynecologist** *(if applicable)*	
Name	Phone	Name	Phone

☐ Primary Care Network (PCN)/Chronic Disease Management (CDM) Team

Name of PCN	Phone Number	Fax Number

Adult Diabetes Referral Criteria** ***(See Page 2 for Pre-Pregnancy/Gestational Diabetes)

*Diagnosis: ☐ Pre-diabetes ☐ Type 1 ☐ Type 2 ☐ Other _____

Date of Diagnosis**:** ☐ less than 6 months ☐ greater than or equal to 6 months

Labwork – Current within 3 months? ☐ Yes

Require at least one of the following: A1C *(preferred)* or Fasting Glucose or Random Glucose

Most Recent Blood Pressure _____ / _____ mmHg.

Previous Diabetes Education ☐ Yes ☐ No	Current Treatment ☐ Diet and Activity ☐ Insulin ☐ Diabetes Medication ☐ Insulin Pump

Recent Hypoglycemic Episodes? ☐ No ☐ Yes If yes did it require emergency room service? ☐ No ☐ Yes Last seen in hospital for diabetes: Date *(yyyy-Mon-dd)* _____	Insulin Pump Education Requested? ☐ Yes

Other Medical Information/Diabetes Concerns ***(i.e. current steroid treatment, pancreatectomy, pancreatitis)***

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Please complete Special Considerations on Page 2

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Pre-Pregnancy/Pregnancy/Gestational Diabetes

Gestational Referrals Require: GDS and/or Oral Glucose Tolerance Test (OGTT)

Weeks Gestation	Estimated Date of Confinement (EDC) *(yyyy-Mon-dd)*	Gravida	Para

Diagnosis ☐ Type 1 ☐ Type 2 ☐ Gestational | Previous GDM ☐ Yes ☐ No

Anticipated Delivery Site:
☐ Royal Alexandra ☐ Grey Nuns ☐ Misericordia ☐ Sturgeon

Pre-Pregnancy Planning ☐ Type 1 ☐ Type 2

Blood Pressure _____ / _____ mmHg

Special Circumstances _____

Special Considerations

☐ Does the person speak English? ☐ Yes ☐ No

If **no**, Please specify alternate language _____

Name of English speaking contact person _____ Phone _____

☐ Cognitive impairment

☐ Hearing, visual impairment, requires oxygen, etc. *Please specify* _____

☐ Activity limitations e.g. walker, cane, etc. *Please specify* _____