TRIDEC: Diabetes Self-Management Centre
60 Grosvenor St
Toronto, ON
M5S 1B6

Telephone: 416-323-6170
Fax 416-323-6085

Name
Address

DOB

WCH MRN

Telephone (H)
(B)

Diabetes Type and History:
_ Type 1 _ Type 2 _ Gestational _ PCOS

Duration ______ yrs.

Special Issues:
_ Language _ Other Needs _ Disability _ Activity Tolerance

____

Significant Medical History:

___ Coronary Artery Disease ___ Neuropathy
___ Hypertension ___ Thyroid Disease
___ Hyperlipidemia ___Depression
___ Peripheral Vascular Disease ___ Foot/Skin Problems
___ Retinopathy ___Other Chronic Illness
___ Nephropathy ______________________

Laboratory Results:

Date _________ FPG _________ 2 hrPG ________ A_1C ________
Date _________ Chol _______ Trig _______ LDL _____ HDL _____
Chol/HDL ratio ________ TSH _____________
Date _________ Proteinuria _______ Ketonuria _________
Date _________ Microalbumin ____ Creatinine ____ MA/Cr Ratio ____
____ copy of recent lab work attached.
Appointment may be delayed until lab results have been received.

Reason for referral:

___ Individual Counselling with diabetes educator
___ Type 1 CHOICES!
____ ADP Pump Program
____ Midlife Women & Type 2
____ Finding Balance
____ Transition Program (Type 1)
____ PCOS Group
____ Type 2 Insulin Group
____ Pregnancy & Pre-Pregnancy Program

Counselling for:

___ Blood Glucose Monitoring ___ Insulin Adjustment
___ Insulin Initiation ___ Nutritional Counselling
___ Stress Management ___ Exercise/Physical Activity

____
____
____
____

Current Medications:

Insulin Orders: _ initiate insulin

	Breakfast	Lunch	Dinner	Bedtime
Humalog/NovoRapid	_____u -	_____ -	_____ -	_____ u
Toronto/Regular	_____u -	_____ -	_____ -	_____ u
N	_____u -	_____ -	_____ -	_____ u
Glargine	_____u -	_____ -	_____ -	_____ u
Premix ___/___	_____u -	_____ -	_____ -	_____ u

Insulin Pump Basal Rates

_____-_____=_____ u/h 1 u = _____ g CHO
_____-_____=_____ u/h Correction factor =
_____-_____=_____ u/h 1 u: _______ mmol/L
____-_____=_____ u/h Target BG goal _______ mmol/L

My signature authorizes the registered nurse to make __ 10% or __ 15% or __ no insulin dose adjustments as necessary.

____
Physician Signature

Date: __________________

Physician mailing address & telephone/FAX/e-mail:

Copy to:

Appt. Date ___________________________________ Time ____________________
For a consultation with an endocrinologist please contact the Endocrine Clinic 416.323.6013 or Dr. A. Kenshole: 416.323.6117