Alexandra Hospital Ingersoll
Tillsonburg District Memorial Hospital

Fax to: ☐ Alexandra Hospital, Ingersoll
Telephone: 519-485-1700 Ext. 8455
Fax: 519-485-9615

Diabetes Education Program (DEP)
Referral Form

Patient: Last name First name	**Address:**	
Phone:	**Date of Birth:** (yyyy/mm/dd)	**Health Card Number:** **Version Code:**

Check Type: ☐ Type 1 ☐ Type 2 ☐ Prediabetes ☐ Type1/Type 2 pregnancy
☐ Gestational Diabetes Mellitus ☐ At Risk for Diabetes (dietitian only)

Date of Diagnosis (yyyy/mm/dd): _____

Other Pertinent Diagnosis: ☐ Mental Health ☐ Dyslipidemia ☐ Hypertension ☐ Other: _____
_____

List All Diabetes Medications and Dose: _____
_____
_____

Reason for referral: _____
_____

☐ Newly Diagnosed ☐ Established ☐ Social Work Support ☐ **Insulin Initiation**: Attach a signed copy of patients insulin prescription.

Medical Directive: Referral to the DEP may include adjustment of insulin & non insulin injectable / Oral Antihyperglycemic Agents

Physician

Print Name: _____ **Date:** (yyyy/mm/dd) _____

Signature: _____

Diabetes Education Program Office Use Only:	
Referral Received (yyyy/mm/dd):	**Appointment Date (yyyy/mm/dd):** **Time (2400hours)**