



ENDOCRINOLOGY & DIABETES UNIT

Endocrinology Clinic: 604-875-2117

Toll-free Phone: 1-888-300-3088, x2117

Fax: 604-875-3231

<http://endodiab.bcchildrens.ca>

**COMMUNITY HEALTH NURSE REFERRAL FORM
FOR CHILDREN WITH DIABETES INSIPIDUS**

Name: _____ Date of Birth: _____

Address: _____ PHN: _____

_____ Home Phone: _____

Parents'/Guardian's Names: _____

School Name: _____ School Phone: _____

Address: _____

Diagnosis: _____

Reason for Referral: to provide education and safety planning for student related to diabetes insipidus, e.g. allow free access to water and bathrooms, recognize signs of dehydration due illness with vomiting or diarrhea or increased urine output, contact family and, if needed, utilize 911 and ambulance for hospital transfer.

Relevant Medical / Social History: _____

Family Doctor: _____ Phone: _____

Pediatrician: _____ Phone: _____

BCCH Pediatric Endocrinologist: _____

Endocrine Clinic Nurse (contact at number above): _____

Doctor Signature: _____ Date: _____

See attached School Management of Central Diabetes Insipidus letter.