ENDOCRINOLOGY & DIABETES PROGRAM

Phone: ______________________________ **Fax:** ________________________________

Endocrinologist: ______________________ **Nurse:** ______________________________

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: ____

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Family Doctor: ____________________________ Phone: ___________________________

Pediatrician: _____________________________ Phone: ___________________________

Doctor Signature: ____