Print Form

ENDOCRINOLOGY & DIABETES PROGRAM

Phone: _____ **Fax:** _____

Endocrinologist: _____ **Nurse:** _____

NURSING SUPPORT SERVICES REFERRAL FORM
FOR CHILDREN WITH DIABETES

Name: _____ Date of Birth: _____

Address: _____ PHN: _____

_____ Home Phone: _____

Parents'/Guardian's Names: _____

School Name: _____ School Phone: _____

Address: _____

Diagnosis: _____ Date of Diagnosis: _____

Reason for Referral: to assist student with blood glucose testing, to monitor for and assist in treating hypoglycemia, and to ensure that all meals and snacks are consumed.

_____

Relevant Medical / Social History: _____

_____

Doctor Name: _____ Doctor Phone: _____

Doctor Address: _____ Doctor Fax: _____

_____

Doctor Signature: _____

Please note that the Canadian Diabetes Association's *Guidelines for the Care of Students Living with Diabetes at School (2014)* is available online at www.diabetes.ca/kidsatschool

Fax this form to Nursing Support Services at 604-453-8301 or email to nssreferrals@cw.bc.ca