ENDOCRINOLOGY & DIABETES UNIT
Diabetes Clinic: 604-875-2868
Toll-free Phone: 1-888-300-3088, x2868
Fax: 604-875-3231
http://endodiab.bcchildrens.ca

BCCH DIABETES PROGRAM REFERRAL FORM

ALERT: IF PATIENT HAS *A NEW DIAGNOSIS OF DIABETES OR DKA*, PAGE THE ENDOCRINOLOGIST ON CALL AT 604-875-2161

Referral Date		**Sex**	□ Male □ Female □ Other □ Transgender
Name of Patient		**DOB** (yyyy/mm/dd)	
Address		**PHN**	
Parents' Names	Mother:	Father:	
	Home/Cell Phone:	Home/Cell Phone:	
	Email:	Email:	
Referring Doctor	Name: Phone: Fax:	MSP #: Next Appointment:	
Interpreter Required?	For Parents: □ Yes □ No Language:	For Child: □ Yes □ No	
Type of Diabetes	□ Type 1 □ Type 2 □ Unknown □ Other:		
	Date of Diagnosis:		
Other Diagnoses	□ Celiac □ Thyroid □ Other:		
Current Insulins (or □ None)	□ Apidra □ Humalog □ NovoRapid □ Other:	□ Levemir □ Lantus □ Basaglar □ NPH □ Other:	
Oral Mediations	□ Metformin □ Other:		
Other Medications			
Diabetes History	Hx of DKA since diagnosis? □ Yes □ No	Unconscious Hypoglycemia? □ Yes □ No	
Prior Diabetes Education	Has had education with: □ RN □ RD When: Where:	□ No prior education received	
Local Diabetes Team	Currently followed by: □ None □ RN + RD □ RN Only □ RD only	Last Seen: Next Appointment:	
Reasons for Referral:			

Essential Information to be provided at time of referral:

Last Height:_____ **Weight:** _____ **Date:** _____

Last A1C: _____ **Date:** _____

Additional useful information to include if available:
- □ Other relevant blood work (e.g. TSH, TPO-Ab, tTG, lipids, OGTT)
- □ Consult notes, diabetes education checklist

For internal Use Only:

To be seen: □ ≤6 weeks □ ≤3 months □ ≤6 months □ >6 months

Visit location: □ Clinic □ DDP

Date Triaged: _____

MD: _____