

Maple Diabetes Referral Form

New referrals will be individually triaged and assigned to group education programs or individual counselling as appropriate.

Patient Name:	Date of Birth:
Referring Provider:	Patient Phone Number(s):
Physician & Physician's Address:	Patient Address:

Diagnosis:

- ☐ Pre-diabetes
- ☐ Type 1 diabetes
- ☐ Type 2 diabetes

Supporting Documents (attach as applicable):

- ☐ Labs (A1C, Lipids, eGFR, ACR, FBG)
- ☐ Medications list
- ☐ Relevant medical/social history

Request for:

- ☐ Diabetes ABCs group program
- ☐ Individual Diabetes Education (RN/RD) consultation
- ☐ Other: _____

If this patient is not suitable for group programs, please indicate the reason here:

Provider Signature: _____

Date: _____

☐ Patient has provided consent to share their Personal Health Information with Maple Diabetes

Fax Referral to Maple Diabetes: 1-888-981-1640

We do not accept referrals for people using insulin pumps – these referrals can be directed to Hotel Dieu Hospital DEC.