Primary Care Diabetes Support Program
P.O. Box 5777, Stn B
London, ON N6A 4V2
Tel: 519-646-6000 ext. 67268
Fax: 519-645-6961

PRIMARY CARE DIABETES SUPPORT PROGRAM REFERRAL FORM

Please complete all **FOUR** sections, **ATTACH** all related documents and **FAX** to the PCDSP at **519-645-6961**.

1. PATIENT INFORMATION Affix LABEL or complete:	**2. REFERRING PHYSICIAN**
Name: _____ J#/PIN: _____ Gender: _____ Date of Birth: _____ Health Card #: _____ Telephone #: _____ Family Physician: _____	*Please print or use a stamp:*

3. MANDATORY – PRIMARY REFERRAL CRITERIA – TYPE 2 DIABETES , A1c >8% AND
Patients must meet ONE of the following criteria (check A, B or C):

❑ **A. No Primary Care Provider (family physician, NP)**	❑ **B. CKD with eGFR <60**	❑ **C. On maximally tolerated glycemic regimen (DPP4i, SGLT2i, Metformin, SU etc.)**

4. PATIENT / TREATMENT HISTORY AND INVESTIGATIONS: EHR/EMR summary

Duration of T2DM: **Brief history of recent glycemic Regimen:**	**Supporting Documents:** *Send copies of the following, if not available on Power chart:* ❑ Health History or Cumulative Patient profile ❑ Recent laboratory investigations including: CBC, A1c, Electrolytes, eGFR, Serum Creatinine, ACR, ALT ❑ Most recent Cardiac assessment i.e. EKG, Cardiology consult note ❑ Medication list ❑ ABPI ❑ ❑ ❑

Additional notes: _____

_____ ***Thank you for your referral!***

Date: _____ ***Please ensure contact information is current.***