MUSKOKA ALGONQUIN HEALTHCARE

Adult Diabetes Education Program Referral Form

Fax to Bracebridge 705 645 3983
please note we do not see pediatric patients

Patient Information

Patient Name:_____
DOB:_____
HRN:_____
Phone Number:_____
Email Adress:_____

Endocrinologist

☐Dr. Cassandra Hawco

Reason for Referral:_____

_____

_____

_____

☐New Diagnosis
☐Type 2 Diabetes
☐Hypoglycemia
☐Pregnancy with Pre-Existing Diabetes
☐Medical Optimization
☐Gestational Diabetes
☐Insulin Pump
☐Recent Treatment for DKA or HHS
☐Type 1 Diabetes
☐Symptomatic Hyperglycemia
☐Uncontrolled DM (e.g. BG>20)
☐Crisis that affects the individuals ability to manage their diabetes
☐T2DM on maximum tolerated oral agents and A1C remains >8%

Current Diabetes Medications:	Other Medications (preference for typed attached document):
Past Medical History (preference for typed attached document):	
Additional Comments:	

Signature of Referring Physician/NP:_____ Date:_____
Referring Physician/NP Name (Print):_____ Billing Number:_____
Physician/NP Office Phone:_____ Office Fax:_____

For MAHC Office Use
Triage By:_____ Date:_____
Action Plan: