

## McMaster Children's Hospital Pediatric Diabetes Program Referral Form

## 2G Clinic Fax 905-521-5056

$\square$ Consult Only $\square$ Consult and Time Limited Follow up	☐ Consult and Share Care ☐ Consult and Transfer Care
Patient Name:	Parent/guardian Names:
DOB://MaleFemale	
Health Card #(OHIP)	Telephone # (Res)(Bus)
Address:	(Cell)
Postal Code:	Who does the patient Reside with?
Telephone: (Res)	☐ Both Parents ☐ Mother ☐ Father ☐ Guardians
(Bus) (Cell)	Custody?
Family Physician	CAS/FACS involvement? ☐ Yes ☐ No
Diabetes Diagnosis: ☐ Type 1 ☐ Type 2	Most recent HbA1c % Date % Date
☐ Other	//0 Bate
☐ Uncertain	Diabetic Ketoacidosis Date
Treatment: ☐ Lifestyle ☐ OHA ☐ Injections ☐ Insulin Pump	Severe Hypoglycemia Date
Reason for Consultation:	
☐ Diagnosis Uncertain ☐ Persistently Elev	ated HbA1c
☐ Recurrent Severe Hypoglycemia ☐ Request for Professional Services or Interdisciplinary Assessment	
☐ Diabetes related vascular complications ☐ Child/Parent/Caregiver Requests Consultation ☐ Other	
Details of Referral:	
Referring Physician Name	Date of Referral
Physician Signature	Billing Number