Ontario
Toronto Central Local Health Integration Network

Toronto Central Diabetes Program Referral Form
for Type 2 Diabetes and Prediabetes

Unison Health & Community Services

Refer immediately to an endocrinologist if client is pregnant, planning pregnancy, or has type 1 diabetes

Fax to: 647-260-0310 Or mail to: Unison Diabetes Education Program, 12 Flemington Road, Toronto, ON M6M 3W2

Personal Information:

Name: _____ **D.O.B. (m/d/y):** _____

Home Address: _____ City: _____

Postal Code: _____ Daytime contact phone #: _____ **Gender:** ☐ M; ☐ F; _____

Type of Diabetes: ☐ Prediabetes; ☐ Type 2 Diabetes; _____ Diabetes Medication: ☐ none; ☐ pills; ☐ insulin; ☐ _____

Preferred program location: ☐ Near home; ☐ Near this major intersection: _____

If a specific site is preferred please indicate so here: ☐ Lawrence Heights (12 Flemington Road) ☐ Keele- Rogers (1651 Keele Street)

☐ Jane – Trethewey (1541 Jane St) ☐ Bathurst Finch (540 Finch Avenue West) ☐ 1651 Dufferin Medical Centre (Partnership site)

Program preferences: Language: ☐ English or _____; ☐ Aboriginal services; Other: _____

Service access challenges: ☐ Mental health challenges: _____; ☐ Developmental challenges: _____

☐ Mobility issues; ☐ Homelessness/housing issues; ☐ Problematic drug and/or alcohol use; ☐ Immigration status (refugee, new immigrant);

☐ No family doctor/nurse practitioner; ☐ Other: _____

Referral Made by:

☐ Myself (self-referral) - See above contact information

☐ Family physician ☐ Nurse practitioner ☐ Endocrinologist

☐ Other professional/organization (☐ *Progress reports desired*)

Referral Made for:

☐ Diabetes self-management education

☐ Prediabetes self-management education

☐ Insulin initiation or adjustment: *Signed order (page 2) must be attached*

Other: _____

Referral Source Contact Information (stamp):

Name (printed):

Profession:

Organization:

Address:

Tel:

Fax:

To be Completed (by Health Care Provider) - only if he or she is the referral source:

Medications (name/dose/frequency): ☐ none ☐ see attached medication list

Oral antihyperglycemic agents: ☐ none or: _____

Insulin/injectable antihyperglycemic agents: ☐ none or: _____

Other medications: ☐ none or: _____

Laboratory Result/Date (used to determine urgency): ☐ see attached labs

AIC		**OGTT: 0 hr**		**LDL**		**TG**		**ACR**	
FBG		**2 hrs**		**TC/HDL**		**eGFR**			

Medical History ☐ see attached

☐ Type 2 diabetes	☐ Cardiovascular disease	☐ Neuropathy
☐ Prediabetes	☐ Retinopathy	☐ Foot/wound concerns:
☐ Dyslipidemia	☐ Nephropathy	☐ Planning pregnancy *(endocrinology referral also required)*
☐ Hypertension	☐ Other/comments:	

Outreach by:

Administration Use Only:

Program/site: _____

Chart #: _____ Received (m/d/y): _____ 1st appointment (m/d/y): _____

Toronto Central **LHIN**
Diabetes Program

Insulin Order & Prescription

For Type 2 Diabetes Management

Refer immediately to endocrinology if client is pregnant, planning pregnancy or has T1DM

Patient/Client's Name: _____
Address: _____
D.O.B. (m/d/y): _____

	CHOOSE: 1. INSULIN & DEVICE	2. DOSE *(subcutaneous)*	3. TITRATION AMOUNT *†Adjustment is made to only one insulin dose per day*	4. CAPILLARY BLOOD GLUCOSE (CBG) TARGETS*
BASAL	**Long-acting analogues (clear)** *Take at one consistent time of the day* ☐ **Levemir®** ☐ Prefilled pen ☐ Cartridge ☐ _____ ☐ **Lantus®** ☐ Prefilled pen ☐ Cartridge ☐ Vials ☐ _____ **Intermediate acting (cloudy)** *Take at one consistent time of the day* ☐ **Novolin®ge NPH** ☐ Cartridge ☐ Vials ☐ _____ ☐ **Humulin® N** ☐ Prefilled pen ☐ Cartridge ☐ Vials ☐ _____	**Once daily dosing:** ___ units at bedtime or ___ units at: _____ **Twice daily dosing:** ___ units at: _____ ___ units at: _____	**†Adjust dose by:** ☐ 1 unit every 1 or more days OR ☐ up to ___ units every ___ or more days	**For evening dosing:** **Adjust dose until fasting CBG is:** ☐ 4.0 – 7.0 mmol/L or ☐ ___ – ___ mmol/L **For morning dosing:** **Adjust dose until ac supper CBG is:** ☐ 4.0 – 7.0 mmol/L or ☐ ___ – ___ mmol/L
BOLUS	**Rapid-acting analogues (clear)** *Take immediately before meal* ☐ **Humalog®** ☐ Prefilled pen ☐ Cartridge ☐ Vials ☐ _____ ☐ **Novorapid®** ☐ Prefilled pen ☐ Cartridge ☐ Vials ☐ _____ Limited use: ☐ 389 ☐ 390 ☐ _____ ☐ **Apidra®** ☐ Prefilled pen ☐ Cartridge ☐ Vials ☐ _____ **Short-acting (clear)** - *Take 30 min before meal* ☐ **Humulin® R** ☐ Cartridge ☐ Vials ☐ _____ ☐ **Novolin®ge Toronto** ☐ Cartridge ☐ Vials ☐ _____	**ac Breakfast:** _____ units **ac Lunch:** _____ units **ac Dinner:** _____ units	**†Adjust BREAKFAST dose by:** ☐ 1 unit every 1 or more days OR ☐ up to ___ units every ___ or more days **†Adjust LUNCH dose by:** ☐ 1 unit every 1 or more days OR ☐ up to ___ units every ___ or more days **†Adjust DINNER dose by:** ☐ 1 unit every 1 or more days OR ☐ up to ___ units every ___ or more days	**Adjust BREAKFAST dose until CBG at:** 2 hr pc breakfast is less than: ☐ 10.0 mmol/L or ☐ ___ mmol/L OR ac lunch is: ☐ 4.0 – 7.0 mmol/L or ☐ ___ – ___ mmol/L **Adjust LUNCH dose until CBG at:** 2 hr pc lunch is less than: ☐ 10.0 mmol/L or ☐ ___ mmol/L OR ac dinner is: ☐ 4.0 – 7.0 mmol/L or ☐ ___ – ___ mmol/L **Adjust DINNER dose until CBG at:** 2 hr pc dinner is less than: ☐ 10.0 mmol/L or ☐ ___ mmol/L
PREMIXED	**Premixed analogues** - *Take immediately before meal* ☐ **Humalog® Mix 25® OR** ☐ **Humalog® Mix 50®** ☐ Prefilled pen ☐ Cartridge ☐ _____ ☐ **Novomix® 30** ☐ Cartridge ☐ _____ **Premixed regular** - *Take 30 min before meal* ☐ **Humulin® 30/70** ☐ Cartridge ☐ Vials ☐ _____ ☐ **Novolin®ge 30/70** ☐ **Novolin®ge 40/60 OR** ☐ **Novolin®ge 50/50** ☐ Cartridge ☐ _____	**ac Breakfast:** _____ units **ac Dinner:** _____ units	**†Adjust BREAKFAST dose by:** ☐ 1 unit every 1 or more days OR ☐ up to ___ units every ___ or more days **†Adjust DINNER dose by:** ☐ 1 unit every 1 or more days OR ☐ up to ___ units every ___ or more days	**Adjust BREAKFAST dose until CBG ac supper is:** ☐ 4.0 – 7.0 mmol/L or ☐ ___ – ___ mmol/L Without causing hypoglycemia post-breakfast. **Adjust DINNER dose until CBG ac breakfast/fasting is:** ☐ 4.0 – 7.0 mmol/L or ☐ ___ – ___ mmol/L Without causing hypoglycemia post-dinner.
MITTE	**Insulin: ____ boxes x ____ repeats** *(Units/box: Cartridges & prefilled pens = 1500, Vials = 1000)* **Supplies: ____ boxes x ____ repeats** ☐ *pen* ☐ *pen needles* ☐ *syringes* ☐ *meter strips* ☐ *lancets*		Notes:	

OTHER ANTIHYPERGLYCEMIC AGENT(S) Rx: Upon Insulin Initiation

To Discontinue:	To Continue (new Rx) *(name, route, dose & frequency):*

Prescriber Information/Stamp:

Name (printed):
License #:
Address:
Tel:
Fax:

Date (m/d/y): _____

Signature: _____

Abbreviations: ac=before meal; pc=after meal; CBG=capillary blood glucose

Adapted from the Ontario College of Family Physicians Insulin Prescription Tool - March 2014

**Additional Reference: Canadian Diabetes Association 2013 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada: appendix 3 - examples of insulin initiation and titration regimens in people with type 2 diabetes. Can J Diabetes 2013: 37(suppl 1): 200-201.*