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

Toronto Diabetes Care Connect

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; ☐ Other

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: ☐ OTC/Supplements: _____

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

A1C		**OGTT: 0 hr**		**LDL**		**TG**		**ACR**	
FBG		**2 hrs**		**TC/HDL**		**eGFR**		**HDL**	

Medical History ☐ see attached Other: _____

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

Administration Use Only:

Program/site: _____ Outreach by:

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

Toronto Diabetes Care Connect

Insulin Order & Prescription Form

For Type 2 Diabetes Management

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

Patient Name: _____

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

	Step 1: Choose Insulin Type to be administered subcutaneously	Step 2: Enter Starting Dose	Step 3: Enter Titration/Adjustment Instructions (Authorization) Amount to adjust dose by[units] and BG target to adjust to [mmol/L]
BASAL	**Long-acting analogues** (clear) ☐ Basaglar™ ☐Prefilled pen ☐Cartridge ☐ Lantus® ☐Prefilled pen ☐Cartridge ☐Vial ☐ Levemir® ☐Prefilled pen ☐Cartridge ☐ Tresiba® ☐ U100 ☐ U200 ☐Prefilled pen ☐ Toujeo™ ☐ SoloSTAR ☐DoubleSTAR ☐Prefilled pen **Intermediate acting** (cloudy) ☐ Humulin® N ☐Prefilled pen ☐Cartridge ☐Vial	**Once daily dosing:** ____units at bedtime ____units at: _____ **Twice daily dosing:** ____units at: _____ ____units at: _____	**†Adjust dose:** ☐1 unit every 1 or more days OR ☐up to____units every____or more days **For evening dosing adjust until Fasting BG is between:** ☐4.0–7.0 mmol/L OR ☐_____–____mmol/L **OR** **For morning dosing adjust until ac Dinner BG is between:** ☐4.0–7.0 mmol/L OR ☐_____–____mmol/L
BOLUS	**Rapid-acting analogues** (clear) Take 0-10 min before meal ☐ Admelog® ☐Prefilled pen ☐Cartridge ☐Vial ☐ Apidra® ☐Prefilled pen ☐Cartridge ☐Vial ☐ Fiasp® ☐Prefilled pen ☐Cartridge ☐Vial ☐ Humalog® ☐Prefilled pen ☐Cartridge ☐Vial ☐ Humalog® 200 units/ml ☐Prefilled pen ☐ Novorapid® ☐Prefilled pen ☐Cartridge ☐Vial ☐ Trurapi™ ☐Prefilled pen ☐Cartridge **Short-acting** (clear) Take 30 min before meal ☐ Humulin® R ☐Cartridge ☐Vial ☐ Novolin®ge Toronto ☐Cartridge ☐Vial	**ac Breakfast:** ___units **ac Lunch:** ___ units **ac Dinner:** ___units	**†Adjust BREAKFAST dose:** ☐1 unit every 1 or more days OR ☐up to____units every____or more days **Until 2hr pc Breakfast BG is less than:** ☐10.0 mmol/L or ☐_____mmol/L **OR until ac Lunch BG is between:** ☐4.0–7.0 mmol/L or ☐_____–____mmol/L **†Adjust LUNCH dose:** ☐1 unit every 1 or more days OR ☐up to____units every____or more days **Until 2 hr pc Lunch BG is less than:** ☐10.0 mmol/L OR ☐_____mmol/L **OR until ac Dinner BG is between:** ☐4.0–7.0 mmol/L OR ☐_____–_____mmol/L **†Adjust DINNER dose:** ☐1 unit every 1 or more days OR ☐up to____units every____or more days **Until 2hr pc Dinner BG is less than:** ☐10.0 mmol/L or ☐_____mmol/L
PREMIXED	**Premixed analogues** (cloudy) Take 0-10 min before meal ☐ Humalog® Mix 25™ ☐Prefilled pen ☐Cartridge ☐ Humalog® Mix 50™ ☐Prefilled pen ☐Cartridge ☐ Novomix® 30 ☐Cartridge **Premixed regular** (cloudy) Take 30 min before meal ☐ Humulin® 30/70 ☐Cartridge ☐Vial ☐ Novolin®ge 30/70 ☐Cartridge ☐Vial ☐ Novolin®ge 40/60 ☐Cartridge ☐ Novolin®ge 50/50 ☐Cartridge	**ac Breakfast:** ___units **ac Dinner:** ___units	**†Adjust BREAKFAST dose:** ☐ 1 unit every 1 or more days OR ☐up to____units every____or more days **Until ac Dinner BG is between:** ☐ 4.0 – 7.0 mmol/L or ☐_____–___mmol/L Without causing hypoglycemia post-breakfast. **†Adjust DINNER dose:** ☐ 1 unit every 1 or more days OR ☐up to____units every____or more days **Until Fasting BG is between:** ☐4.0 – 7.0 mmol/L or ☐_____–___mmol/L Without causing hypoglycemia post-dinner.

MITT

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: _____

Adapted from: the Ontario College of Family Physicians Insulin Prescription Tool - March 2014 using the 2013 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada (Diabetes Canada) and revised September 2017, April 2018 & July 2022 to include new insulins

Abbreviations: CBG=capillary blood glucose (mmol/L); ac=before meal; pc=after meal **†Adjustment is made to one insulin dose per day**