

Referral Form

Patient's Name:	Date of Birth:
Referring Provider:	Patient Phone Number:
Physician and Physician's Address:	Patient Address:

Referral for:

- Pre-diabetes
- Type 1 diabetes
- Type 2 diabetes

Supporting documents (attach as applicable)*:

- Labwork: FBG, HbA1c
- Current medications
- Relevant medical history

* additional information may be requested from **maple diabetes** upon receipt of referral

Request for:

- Individual RD-RN (Diabetes Educator) consultation
- Group program
- Other: _____

Provider Signature: _____

Date: _____

Fax referral to: (613) 531-5887, attention: maple diabetes

We do not accept referrals for gestational diabetes, type 1 diabetes individual consults or insulin pump therapy. For these conditions, refer to Hotel Dieu Hospital.