Barrie Community Health Centre

Adult (18 and over) Diabetes Management Centre – Self Referral Form

490 Huronia Road Barrie, Ontario L4N 6M2
Phone: (705) 734-9690 ext 283 Fax: (705) 719-4877

Last Name: ______________________ **First Name:**___________________________

Date of Birth: _____________________ **Health Card #:** _______________________ **VC:** ____

Address: ________________________ **City/Town:** ___________ **Postal Code:** _________

Telephone: H: _______________ **W:** ________________ **Cell:** _______________

****** Barrie Community Health Centre is an insulin pump centre ******
Clients must be at least 18 years old

New Diagnosis: □ **Yes** □ **No** **If no, how long have you had Diabetes?** ________________

Reason for Referral: □ **Pre-diabetes** □ **Type 1 (□ Insulin Pump)**
□ **Type 2** □ **Gestational Diabetes**

Medical History (check all that apply):

___Family history of diabetes	___Heart attack	___Nerve damage	___Gestational diabetes
___High blood pressure	___Heart disease	___Eye problems	___Smoker
___High cholesterol	___Heart failure	___Kidney damage	___Overweight/Obesity

___Mental Health (bipolar, depression, schizophrenia): please list: ______________________

___Other: ____

Diabetes Medications:

Oral: ____

Insulin/Injectable: ____

Other Medications: ____

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Allergies:____

Do you have a Family Physician? □ **Yes** □ **No** **Name:** ______________________

Physician's Tel: __________________ **Fax:** _______________________

□ I authorize the staff from the Diabetes Management Program to contact my family physician and to obtain a copy of my most recent lab work. ***Please check if you give permission to access lab results.**

Signature:________________________ Date:________________________