



Diabetes Care Services-Self Referral Form

First Name: _____ Last Name: _____

Date of Birth (Day/Month/Year)

Health Care Number:

Address: _____

City: _____

Postal Code: _____

Home Phone: () _____

Cell Phone: () _____

May we leave a message regarding an appointment? ☐ Yes ☐ No

Primary Care Provider: _____

Preferred Language: ☐ English ☐ French ☐ Other

How long have you had diabetes or high blood sugar?

Have you had diabetes education in the past? ☐ Yes ☐ No

Diabetes treatment: ☐ Diet only ☐ Diet & Pills ☐ Diet & Insulin ☐ Diet, Pills & Insulin

Have you been hospitalized for your diabetes in the past year? ☐ Yes ☐ No

Are you treated for any of the following?

☐ High Blood Pressure ☐ Eye Disease ☐ High Cholesterol/Triglycerides ☐ Kidney Disease ☐ Other

Type of Diabetes: ☐ Type 1 ☐ Type 2 ☐ Gestational Diabetes ☐ Other _____

What is the name of the pharmacy you deal with _____

This program offers individual appointments with Registered Nurses, Registered Dietitians, Social Workers and Group Classes. What interest you? _____

**** Are you interested in workshops on how to better manage your health? Yes No**

Workshops include Diabetes Self Management Program (Once a week for 6 weeks in person-2.5 hours), Diabetes Healthy Feet and You (one time session-2.5 hours) , Nutrition Class (one time session- 2 hours).

Signature

Date Completed

Please email completed form to Diabetescareservice@hsnsudbury.ca or you can drop it off at the Sudbury Centre at 865 Regent St. South, Sudbury, ON P3E 3Y9 Telephone # 705-671-6601