Health Sciences North
Horizon Santé-Nord

# Diabetes Care Services-Self Referral Form

Name:_____ Address:_____

Health Card Number:_____ Family Physician_____

Telephone number:_____

**First Language:** ☐English ☐French ☐Other _____

**How long have you had diabetes or high blood sugar?**_____

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

**How is your diabetes treated:** ☐Diet only ☐Diet & Pills ☐Diet & Insulin ☐Diet, Pills & Insulin

**Have you been hospitalized for your diabetes in the past year?** ☐Yes ☐No
**When:**_____ **Where:**_____

**Are you being treated for any of the following?**

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

☐Other

**Type of Diabetes:** ☐Impaired Glucose Tolerance ☐Impaired Fasting Glucose ☐Secondary Diabetes

☐Type 1 ☐Type 2 ☐Gestational Diabetes ☐Other_____

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

_____ _____

*Signature* *Date Completed*