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: _____

_____

Other Medications: _____

_____

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 as needed and to obtain a copy of my most recent lab work. ***Please check if you give permission to access lab results.**

Signature: _____ Date: _____