thewellness Institute

Diabetes Wellness Referral Form

Surname:	Given Name:	
Home Ph:	Work Ph:	Mobile Ph:
Address:		Postal Code:
Email:		D.O.B. (M/D/Y):
MHSC:	PHIN:	
Primary Health Care Provider:	Address or Clinic Name:	Fax:

Medical History (please attach summary):

Diabetes: ❑ Type I ❑ Type II

Lab Values: A1C _____ FBS _____ (Ask patient to bring BS log)

Medications (please attach list):

Referred by: ❑ Community Health ❑ Wellness Programs
❑ Primary Care Provider ❑ Self Referral
❑ Other _____

Nature of referral: ❑ Medication Assessment ❑ Diet/Lifestyle ❑ Other _____

Is patient receiving Diabetes counselling elsewhere? ❑ Yes ❑ No

If yes, by whom? _____

Referring Practitioner: Name: _____

Signature: _____

Communication to be directed to:

❑ Primary Care Provider: _____

❑ Other: _____

Please fax referral to **the Wellness Institute** Fax: 204-633-3753 Phone: 204-632-3910