

Type I Diabetes Request and Treatment Order

Patient Information

Patient Surname		Patient First Name	
Guardian/Contact Name		Guardian/Contact Telephone Number	
Patient Home Address			
City		Postal Code	
Health Card Number (HCN)	Version Code	Date of Birth (YYYY-Month-DD)	
Name of School			

Referral Details

Diagnosis Type 1 Diabetes Mellitus	Planned Treatment Start Date (YYYY-Month-DD)	Is client aware of referral? <input type="radio"/> No <input type="radio"/> Yes
Reason for Referral Child requires school support with: <input type="checkbox"/> insulin administration <input type="checkbox"/> blood glucose monitoring		
Timing		

Referrer Details

Referrer Name and Designation	CNO/College of Dietitians Registration
Direct Telephone Number	Fax Number

X _____
Referrer Signature Date Signed (YYYY-Month-DD)

Important Information

Child and family to return to Children's Hospital LHSC for ongoing diabetes education and support.
If questions or concerns, please contact the appropriate Diabetes team member at **(519) 685-8500**.

Physician Details

Physician Name and Designation	Orders
CPSO/ Registration	
Direct Telephone Number	
Fax Number	
Physician Signature	
Date Signed (YYYY-Month-DD)	

Physician Signature for orders is required under Regulated Health Professional Act. **Note: Family is able to self-adjust insulin by 20% as per physician's order. Please discuss site rotation plan with caregivers.**