



SOUTHWEST ONTARIO ABORIGINAL HEALTH ACCESS CENTRE
GANAAAN DE WE O DIS ^YETHI YENAHWAHSE

Referral Form

Indicate Referral Location:

- London: 425-427 William St. London, ON N6B 3E1 Tel: 519-672-4079 Fax: 519-672-6945
 Chippewa of the Thames: 4 Anishinaabeg Dr. Muncney, ON, P.O. Box 426 N0L 1Y0 Tel: 519-289-0352 Fax: 519-289-0355

Date of Referral: _____

Clients Name: _____ DOB: _____

Address: _____ Phone Number: _____

Family Doctor: _____ Phone: _____

Address: _____ Fax: _____

Services Requested: Type 2 Education Pre-Diabetes (IGT/IFG) Education Foot Care
 Type 2 Insulin initiation (see below) Other: _____

Current Medications: _____

Recent Labs: _____ Attached

Comments: _____

For Clients being started on insulin:

Type of insulin: NPH/N Levemir Lantus other: _____

Starting Dose: _____

Will you allow the Diabetes Educators to adjust insulin dosages? Yes

No: *please indicate titration orders:* _____

Discontinue TZD? Yes No When? _____

Physician Signature: _____