

Weight Management Referral

**This program is open for adults 18 years and older, with BMI of 27 or higher.*

Exceptions: Eating disorders, alcohol abuse, active suicidal ideation, within 1 year of post bariatric surgery.

Fax referral to Diabetes Education Center at Markham Stouffville Hospital at 905-472-7533								
<i>If this section is selected, would you like diabetes services provided for the selected patient as well?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No								
Please select one of the following locations for diabetes education management								
<input type="checkbox"/> Adult Diabetes Education Centre Fax: 905-472-7533 Tel: 905-472-7527 (Type 1, Type 2 & Prediabetes)				<input type="checkbox"/> Carefirst Diabetes Education Program Fax: 905-695-0826 Tel: 905-695-1140 (Type 2, Prediabetes & At-risk)				
Name:			Gender: <input type="checkbox"/> M <input type="checkbox"/> F		DOB (dd/mm/yyyy)			
Address:			Hm. Phone #		Wk. Phone #			
City:		Postal code:		Health Card #				
Referring MD:		Referring MD Signature:			Phone #:		Fax #:	
Obesity								
<input type="checkbox"/> Overweight (BMI >27)			<input type="checkbox"/> Obesity Class II (BMI 35 - 39.9)					
<input type="checkbox"/> Obesity Class I (BMI 30 - 34.9)			<input type="checkbox"/> Obesity Class III (BMI greater than 40)					
Exercise restrictions <input type="checkbox"/> Yes <input type="checkbox"/> No - Comment: _____								
Type of Diabetes								
<input type="checkbox"/> Type 1 (at Markham site only)			<input type="checkbox"/> Prediabetes (Impaired Glucose Tolerance)					
<input type="checkbox"/> Type 2			<input type="checkbox"/> At risk (at Carefirst site only)					
Date of Diagnosis: _____								
Health History			<input type="checkbox"/> Neuropathy			<input type="checkbox"/> Dyslipidemia		
<input type="checkbox"/> See attached			<input type="checkbox"/> Retinopathy			<input type="checkbox"/> Foot/Skin Problems		
<input type="checkbox"/> Cardiac Hx _____			<input type="checkbox"/> Nephropathy			<input type="checkbox"/> Obesity		
<input type="checkbox"/> Vascular disease			<input type="checkbox"/> Mental Health Concerns			<input type="checkbox"/> Exercise Restrictions		
<input type="checkbox"/> Hypertension			<input type="checkbox"/> Other _____			Allergies: <input type="checkbox"/> NKA		
Lab Data (within the last 3 months) <input type="checkbox"/> See attached								
Date	FBG/RBG	HbA1C	CHOL	HDL	LDL	TRIG	Creatinine	Microalbumin/Creatinine Ratio
Current Diabetic Medications / Dose / Timing:								
Oral Hypoglycemic Agents:								
Insulin:								
Other Medications:								

