Rideau Community Health Services
Your Community Health Centre

Smiths Falls Site
2 Gould Street, Unit 118
Smiths Falls, ON, K7A 2S5
Ph: 613-284-2558 or 1-877-321-4500
Fax: 613-284-2591
Website: www.rideauchs.ca

Brockville Site
100 Strowger Boulevard, Suite 107
Brockville, ON, K6V 5J9
Ph: 613-498-1555
Fax: 613-498-9922
Website: www.rideauchs.ca

Diabetes Education Program Referral Form

RCHS Diabetes Education Program accepts referrals for adults (18+) diagnosed with diabetes (type 1 or type 2) or prediabetes for education and management support. Our educators (registered nurse or registered dietitian) will triage each referral to offer your patient either group-based or individual diabetes education, based on the information provided and patient preference. For more information about our programming, please visit our website: **www.rideauchs.ca/programs-services/diabetes-education**

Note: We do accept referrals for gestational diabetes for interim teaching on SMBG, BG targets and diet while awaiting initial appointment with high-risk programs at tertiary centres.

Patient information:
Full Name _____
Address _____
Home Ph # _____ Cell # _____
Date of Birth DD-MM-YYYY E-Mail _____
HC # _____ Version Code____ Expiry date_____

Referring Health Care Provider:
Name _____
Office Location _____
Phone # _____
Fax # _____

Please ensure the following are attached (required):
- ✓ Current medication list
- ✓ Recent lab work *(A1C, FBG, eGFR, ACR, Lipids)*
- ✓ Relevant medical history or problem list

Diagnosis: ☐ Prediabetes ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Other:_____

Duration of Diagnosis: ☐New Diagnosis (<6 months) ☐ _____ years

Services Requested (Select all that apply):
- ☐ Diabetes Education and Support
- ☐ Insulin initiation*
- ☐ Insulin adjustment*
- ☐ GLP-1 Initiation/Adjustment
- ☐ Diabetes Home Monitoring program

* Any client referred for insulin initiation or adjustment requires a Medical Delegation to be completed and sent in with the referral. These forms can be accessed on our website.

Please identify any challenges that may impact learning or service(s) requested if applicable (eg. cognitive, mental health, literacy, homeless/marginal housing, mobility, etc.) or other additional comments:

Signature of Referring Health Care Provider: _____ Date DD-MM-YYYY