East Wellington Family Health Team

Diabetes Care Program
Self-Referral Form

To attend this program you must be:

- over the age of 18
- have a confirmed diagnosis of Pre-diabetes or Diabetes (Type 1 or Type 2)

Please complete the following information and drop it off at our Rockwood or Erin clinic.

****By completing and signing this form you are giving our clinic permission to contact your doctor for more information if it is required****

Name: _____ Male ☐ Female ☐

Home phone: _____ Work/Cell phone: _____

Address: _____

Email address: _____

Date of birth: _____ HCN: _____

Family Doctor: _____ Phone number: _____

Name of the pharmacy you use: _____

Do you have? Pre-diabetes ☐ Diabetes ☐

How long have you had diabetes? _____

Do you have any allergies? Yes ☐ No ☐

If yes, what are your allergies? _____

Is there anything you would like to tell us about yourself? _____

_____

When is the best time to contact you? _____

When is the best time for appointments? Daytime ☐ Evening ☐

If possible, please attach recent blood work results and an up-to-date medication list.

Patient signature: _____ Date: _____

Thank you for completing this self-referral form.
We will contact you soon and look forward to meeting with you.

March 2019