Updated Dec 2012

Diabetes Education Program (DEP)

Referral Form for Eastern Counties Champlain Region

Centre de santé communautaire de l'Estrie
Clinique de diabète/ Diabetes Clinic[3]

☐ Alexandria[3] Fax: 613-525-3991
Tel.: 613-525-5544

☐ Bourget[3] Fax: 613-487-4182
Tel.: 613-487-1802

☐ Cornwall[3] Fax: 613-937-4938
Tel.: 613-937-0478
Toll free: 1-855-342-2338

☐ Crysler[3] Fax: 613-987-9908
Tel.: 613-987-2683

☐ Embrun[3] Fax: 613-443-9519
Tel.: 613-443-3888

☐ **Cornwall Community Hospital Diabetes Centre[3, 4, 5]**
Fax: 613-936-4623, Tel.: 613-936-4615
- Multidisciplinary team / Specialist consultation available with Dr. T. Baitz, Dr. J.P. DeYoung or Dr. M.F. Levac
- Glengarry Seniors Support Centre, Lancaster

☐ **Hawkesbury & District General Hospital Diabetes Clinic[3, 4, 5]**
Fax: 613-636-6194, Tel.: 613-632-1111 ext. 52701
- Multidisciplinary team / Specialist consultation available with Dr. M. Thibodeau

☐ **Mohawk Council of Akwesasne Diabetes Education Centre[1]**
Fax: 613-575-1152, Tel.: 613-575-2341, ext. 3247
- Home Care and Support Program

☐ **Winchester District Memorial Hospital Diabetes Education Program[1]**
Fax: 613-774-6536, Tel.: 613-774-2422, ext. 6765
- Specialist consultation available with Dr. C. Irobi

1. English only *2. French only* *3. Bilingual*
4. Gestational diabetes *5. Pump initiation*

For a full list of diabetes services: Champlain Diabetes Regional Coordination Centre: http://www.champlaindrcc.ca/

Client's name:
Preferred language of service: ☐ French ☐ English ☐ Other: _____
Address:
Telephone # (home):
Telephone # (work):
Date of birth:
Health card #:

☐ Newly diagnosed
☐ Established diabetes
☐ Type 1 diabetes
☐ Type 2 diabetes
☐ Pre-diabetes (IFG/IGT)
☐ Gestational diabetes

Requested services (please check all that apply):

☐ Individualized counseling by nurse and dietitian and/or group education
☐ Insulin initiation (please fax your insulin prescription - available at: **www.ocfp.on.ca**)
☐ Initiation of GLP-1
☐ Pump initiation and follow-up
☐ Specialist consultation:
Dr. _____
(name of physician)

Comments / Special concerns:

Health care provider:

Signature:

Telephone number:

Date:

Please fax blood work, medication list and medical history with referral. Thank you.