FIRST NATIONS HEALTH AND SOCIAL SECRETARIAT OF MANITOBA

Diabetes Integration Project
Referral Form

DATE OF REFERRAL (DD/MM/YYYY)

_____/_____/_____

DATE REFERRAL RECEIVED: (OFFICE USE ONLY)

/ /

CLIENT INFORMATION

Is Client Aware of Referral? ☐ **YES** ☐ **NO**

Surname **Given Name** **Middle Name** **Home/Message Phone No.**

Mailing Address (Street / Box No.) **City/Town** **Province** **Postal Code** **Work Phone No.**

First Nation Community **10 digit Treaty No.** **MHSC No.**

Gender
☐ Male ☐ Female

/ /
Date of Birth (dd/mm/yyyy) **Age** **PHIN NO.**

CLIENT'S PHYSICIAN **CLINIC** **PHYSICIAN'S PHONE NO.**

REASON FOR REFERRAL

☐ Newly Diagnosed ☐ Risk Factor Assessment ☐ Insulin Start
☐ Complication Assessment ☐ Update Knowledge ☐ Insulin Adjustment ☐ Other _____

Date or Year Client was Diagnosed with Type 2 Diabetes _____
DD/MM/YYYY

RESULTS

Fasting Blood Sugar **Glycated Hemoglobin** **Albumin:Creatinine Ratio** **Date**

Cholesterol **HDL-C** **LDL-C** **Triglycerides** **Date**

Blood Pressure **Date**

Complications:

☐ Neuropathy ☐ Nephropathy ☐ Peripheral Vascular Disease ☐ Foot Problems ☐ Sexual Dysfunction
☐ Retinopathy ☐ Hypertension ☐ Cardiovascular Disease ☐ Other _____

List Medication Dosage & Frequency

Signature & Title of Person Referring **Organization/Clinic** **Phone No.**

First Nation Communities Receiving DIP Services Include:
Hollow Water, Long Plain, Peguis, Sandy Bay, Swan Lake
Send Referral To:
FNHSSM Diabetes Integration Project, Suite 600 - 275 Portage Avenue, Winnipeg, MB R3B 2B3
Phone: (204) 956-7174 Fax: (204) 946-9761