FRASER HEALTH PAEDIATRIC DIABETES REFERRAL PROCESS AND FORM

DOCTORS IN THE COMMUNITY:

SUSPECTED TYPE 1 Pediatric patient in the community: the patient and family should be sent to emergency to be stabilized and will either need to be admitted for inpatient teaching at SMH, RCH or ARH or stabilized and referred for outpatient teaching at BC Children's hospital.

NEW DX T1D			
RCH-ER **INPATIENT TEACHING**	**SMH-ER** **INPATIENT TEACHING**	**ARH-ER** **INPATIENT TEACHING**	**BCCH-ER** **INPATIENT OR OUTPATIENT TEACHING**
*****ONCE INITIAL TEACHING IS DONE A REFERAL CAN BE SENT FOR ONGOING OUTPATIENT CLINIC FOLLOW UP AT ONE OF THE LOCATIONS BELOW*****			
ERH **Ongoing Follow Up**	**SMH** **Ongoing Follow Up**	**ARH** **Ongoing Follow Up**	**BCCH** **Ongoing Follow Up**

SUSPECTED TYPE 2 Pediatric patient in the community: the patient should be stabilized and referred to one of the pediatric diabetes centers. **For those individuals requiring insulin**, inpatient teaching or teaching via BCCH's Outpatient day program would be required.

ESTABLISHED TYPE 1 OR TYPE 2: a referral form (see page 2) should be sent with all the recent labs, growth chart and visits to the appropriate diabetes center. ***If the patient has been seen at BC Children's they will need to inform their Endocrinologist and cancel any existing appointments.***

PLEASE MAIL OR FAX COMPLETED FORM TO THE APPROPRIATE CENTER

SMH Pediatric Diabetes Clinic
Charles Barham Pavilion, Surrey Memorial Hospital
13750 96th Ave, Surrey BC, V3V 1Z2
Phone: 604-587-3929
Fax: 604-585-5968

ARH Pediatric Diabetes Clinic
Pediatric Diabetes Clinic
32900 Marshall Rd, Abbotsford, BC V2S 0C2
Phone: 604- 851-4700 Ext. 646267
Fax: 604- 851-4790

Tri Cities Diabetes Health Centre
475 Guildford Way, Port Moody, BC V3H 3W9
Phone: 604- 949-7771
Fax: 604- 949-7772

FRASER HEALTH AUTHORITY
PAEDIATRIC DIABETES REFERRAL FORM

Date of Referral: ______________________ **Date of Diagnosis:** ______________________________

Reason for Referral

- □ **Type 1 Diabetes New Dx**
- □ **Type 2 Diabetes New Dx**
- □ **Prediabetes New Dx**
- □ **Type 1 Diabetes Transfer of Care**
- □ **Type 2 Diabetes Transfer of Care**
- □ **Prediabetes Transfer of Care**

Additional information:

□**Social or family concerns:** ____

□**History of recent hospitalization:** ____

□**Other:** ____

Patient's Name: ____________________________________
SURNAME, Given name

Date of Birth: _______/______/______
(day / month / year)

Gender: □ **Male** □ **Female** □ **Transgender** □ **Other**

PHN: ____________________________________

Medication(s) : ____________________________________

Insulin: □ **Pen** □ **Syringe** □ **Pump** ____________
Pump brand

Parent(s)/guardian's name(s): _________________________

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History and LAB Checklist:

- Last Consult
- A1C
- FBS, OGTT
- TSH, ATPO
- Chol profile
- TTG, IgA
- GAD antibodies
- Social Work Notes
- Food/Nutrition Hx
- Growth Chart

Address: ____ **Postal Code** ______________________

Home phone: ___________________________

Work phone: ___________________________

Cell phone: ___________________________

Language Spoken: _____________

Interpreter Required: □ **Yes** □ **No**

Interpreter Booked: □ **Yes** □ **No**

Referring Pediatrician: ____________________ **Family Physician:** __________________________

Phone #: _______________________________ **Phone #:** _________________________________

Fax #: ___________________________________ **Fax #:** ____________________________________