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.

<table>
<thead>
<tr>
<th>NEW DX T1D</th>
<th>RCH-ER</th>
<th>SMH-ER</th>
<th>ARH-ER</th>
<th>BCCH-ER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>INPATIENT TEACHING</td>
<td>INPATIENT TEACHING</td>
<td>INPATIENT TEACHING</td>
<td>INPATIENT OR OUTPATIENT TEACHING</td>
</tr>
</tbody>
</table>

***ONCE INITIAL TEACHING IS DONE A REFERAL CAN BE SENT FOR ONGOING OUTPATIENT CLINIC FOLLOW UP AT ONE OF THE LOCATIONS BELOW***

<table>
<thead>
<tr>
<th></th>
<th>ERH</th>
<th>SMH</th>
<th>ARH</th>
<th>BCCH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ongoing Follow Up</td>
<td>Ongoing Follow Up</td>
<td>Ongoing Follow Up</td>
<td>Ongoing Follow Up</td>
</tr>
</tbody>
</table>

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 1 Diabetes Transfer of Care |
| □ Type 2 Diabetes New Dx | □ Type 2 Diabetes Transfer of Care |
| □ Prediabetes New Dx | □ 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): ___________________________

Address: ____________________________________________

Postal Code __________

Home phone: ____________________________

Work phone: ____________________________

Cell phone: ____________________________

Referring Pediatrician: ________________

Family Physician: ______________________

Phone #: ____________________________

Phone #: ____________________________

Fax #: ____________________________

Fax #: ____________________________

Language Spoken: __________

Interpreter Required: □ Yes □ No

Interpreter Booked: □ Yes □ No