

**GARDEN CITY - DIABETES CARE TEAM**

**145**

**Carlton Street**

**DIABETES EDUCATION PROGRAM**

**St**

**Catharines, ON**

**GCFHT REFERRAL FORM – OFF-SITE**

**L2R 1R5**

**FAX 905-688-0047  
9617 ext 226**

**PHONE: 905-988-**

**REFERRING PHYSICIAN / PROVIDER: \_\_\_\_\_ Date: \_\_\_\_\_**

**REASON FOR REFERRAL & SPECIFIC CONCERNS:**

**NO TYPE 1, PAEDIATRIC, OBSTETRICAL OR PUMP REFERRALS. REFER TO REGIONAL DIABETES PROGRAM.  
AT PRESENT WE ACCEPT TYPE II INSULIN START REFERRALS FOR COMPETENCY TRAINING ONLY.**

Patient \_\_\_\_\_  
(attach label if preferred)

DOB \_\_\_\_\_  
dd/mm/yyyy

Age \_\_\_\_\_

Address \_\_\_\_\_

Phone (Home) \_\_\_\_\_

Alternate Contact Person \_\_\_\_\_

(Other) \_\_\_\_\_

\_\_\_\_\_  
(telephone number)

