tel/text: 1-587-882-4477
fax: 1-587-760-4567
PO BOX 84210 Market Mall, Calgary AB T3A 5C4

OKAKI Diabetes Virtual Care Clinic Referral Form

Referring Health Care Provider (required)		
Name	Clinic Address	Clinic Phone
Practice ID (required)		Clinic Fax

Patient Details		
Name	Full Address	Home Phone
Date of Birth		Cell Phone
PHN	Email Address	Clinic contact person (if applicable)
Gender Identity	**Best contact method:**	

Diabetes Type & Duration		Referral for: (select all that apply)
☐ Type 2 ☐ Prediabetes Duration: ☐ < 6 months	☐ Type 1 ☐ Other: ☐ >6 months	☐ Endocrinologist Appointment ☐ one time consultation ☐ assumption of care ☐ Certified Diabetes Educator Appointment ☐ Diabetes Education Group Classes

Pertinent Medical History		Referral Details
Relevant Comorbidities: ☐ Hypertension ☐ Dyslipidemia ☐ Obesity ☐ Obstructive Sleep Apnea	Diabetes Complications: ☐Cardiovascular disease ☐Peripheral vascular disease ☐ Neuropathy ☐ Nephropathy ☐ Retinopathy	**Most recent HbA1C:** **Date:**

Community Health Centre Clients	
Please check the most suitable day for a local health centre teleconference visit: ☐ Wednesday ☐ Thursday	

Please attach a current medication list with referral.