DIABETES CENTRE (DC) REFERRAL FORM

Please complete the following information. It will serve as a referral to the DC as well as Registry data for the Diabetes Care Program of Nova Scotia (DCPNS). The back of this form provides definitions, diagnostic criteria, and recommended target values.

DATE OF DIAGNOSIS (dd/mm/yyyy): _____

DATE REFERRED (dd/mm/yyyy): _____

NAME: _____
LAST FIRST INITIAL

ADDRESS: _____
STREET

_____
CITY/TOWN POSTAL CODE

HEALTH CARD#: | | | | | | | | | | |

SEX: ☐ **M** ☐ **F** **DOB** (dd/mm/yyyy): _____

PHONE (H): _____ **(W):** _____ **(C):** _____

PARENT/GUARDIAN: _____

DC USE ONLY
DC Appt. (dd/mm/yyyy): **Type of Referral**: ☐ ND ☐ NND ☐ NNDR **Previous DM Education**: ☐ Y ☐ N **When/Where?**

TYPE OF DIABETES (Definitions on back)

☐ Type 1 ☐ Type 2
☐ Impaired glucose tolerance (IGT)
☐ Impaired fasting glucose (IFG)
☐ IFG & IGT
☐ Other _____

IF PREGNANT CHECK BELOW:
☐ Type 1 ☐ Type 2 ☐ GDM
EDC _____

PRESENT TREATMENT

☐ Lifestyle only
☐ Oral antihyperglycemic (OA)
☐ Injectable (non-insulin)
☐ OA & Injectable
☐ Insulin
☐ Insulin & OA
☐ Insulin & Injectable
☐ Insulin & OA & Injectable

MEDICAL PROBLEMS ☐ **NONE**

☐ Thyroid
☐ Hypertension (> 140/80)
☐ Dyslipidemia
☐ Cardiovascular Disease (CVD)
☐ Smokes
☐ Alcoholism
☐ Overweight (BMI > 25)
☐ Exercise Restrictions _____
☐ Other _____

MICROANGIOPATHY
☐ Retinopathy
☐ Nephropathy

MISCELLANEOUS
☐ Foot Problems
☐ Neuropathy

FAMILY HISTORY (parents/siblings/children only)

Diabetes	☐ Yes	☐ No
Cardiovascular Disease	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Obesity	☐ Yes	☐ No

LABORATORY DATA: Please complete this section to verify new diagnosis & to prevent duplication of testing.

MEDICATIONS (diabetes-related and other) ☐ **None**

☐ **Patient told to bring medications to DC**
(Name/Dose/Frequency)

_____
_____
_____
_____
_____
_____
_____
_____

☐ **REFERRAL FOR INSULIN START**

BASIS OF DIAGNOSIS

SYMPTOMATIC: ☐ Y ☐ N

DATE: _____

☐ FPG: _____
☐ RANDOM PG: _____
☐ 75 g OGTT (2 hr): _____
☐ A1C:* _____

CONFIRMATORY TEST: ☐ Y

DATE: _____

☐ FPG: _____
☐ RANDOM PG: _____
☐ 75 g OGTT (2 hr): _____
☐ A1C:* _____

GDM (Gestational) ONLY

☐ **50 g GCT** (glucose challenge test)

DATE: _____

1 hr: _____

☐ **75 g OGTT**

DATE: _____

FPG: _____
1 hr: _____
2 hr: _____

*Not for diagnostic use in children, youth, pregnant women, or those suspected of type 1 diabetes. Caution in the elderly and certain ethnic groups.

BASELINE DATA

REREFERRAL (RECENT)

DATE: _____

☐ A1C: _____
☐ FASTING PG: _____
☐ RANDOM PG: _____

ALL REFERRALS (check if completed in the past 3 months)

☐ A1C
☐ LDL
☐ TG
☐ CREATININE (eGFR)
☐ ACR
☐ TSH
☐ LIVER FUNCTION

PROBLEMS THAT MAY AFFECT LEARNING:

☐ Physically Challenged ☐ Mentally Challenged ☐ Social Situation
☐ Attitude Toward Diabetes ☐ Financial ☐ Literacy
☐ Drug Use ☐ Emotional

Referrals to specialty services (e.g., Home Care/VON, Diabetes Specialist, Foot Care Services, etc.) must be made directly by the referring provider.

COMMENTS/SPECIAL INSTRUCTIONS:

☐ **Transferred from DC (NAME):** _____

Referring Physician/NP (Please Print): _____
NAME PHONE SIGNATURE

☐ Check if family physician/NP same as referring

DEFINITIONS:

Type 1 DM: Absolute deficiency of insulin secretion as a result of pancreatic β–cell destruction; prone to ketoacidosis.
Management: Insulin & nutrition therapy and other lifestyle modifications. Usual onset is under age 35 years.

Type 2 DM: Resistance to insulin and/or inadequate compensatory insulin secretory response.
Management: Nutrition therapy & other lifestyle modifications; antihyperglycemic agents (oral & injectable); insulin. Usual onset is over age 35 years.

Gestational Diabetes (GDM): Any degree of glucose intolerance with first onset or first recognition during pregnancy.

Prediabetes: Not a diagnosis of diabetes; intermediates between normal glucose homeostasis and DM. Includes impaired glucose tolerance (IGT) and/or impaired fasting glucose (IFG). These are risk factors for future DM and cardiovascular disease (CVD).
Management: Lifestyle modification—nutrition therapy (weight loss), smoking cessation, and physical activity/exercise. Pharmacotherapy in IGT may be used to reduce the risk of type 2 DM (biguanide or alpha-glucosidase inhibitor).

DIAGNOSTIC CRITERIA FOR DM IN THE NONPREGNANT ADULT:

1. A FPG ≥ 7.0 mmol/L. Fasting = no caloric intake for at least 8 hours. **OR**
2. Random plasma glucose (PG) value ≥ 11.1 mmol/L. Random = any time of the day, without regard to time since last meal. Confirm with an alternate test. **OR**
3. The PG value in the 2-hr sample of the 75g OGTT is ≥ 11.1 mmol/L. **OR**
4. A1C ≥ 6.5% **(in adults). DO NOT use in children, adolescents, pregnant women, or in those suspected of type 1 diabetes.** It may be misleading in those with hemoglobinopathies, iron deficiency, hemolytic anaemias, severe hepatic, and renal disease. There are also variations in non-Caucasian ethnicities and the elderly.

For all of the above (1-4), in the absence of symptomatic hyperglycemia, a repeat confirmatory laboratory test must be done on another day.

Pediatric Population (children/adolescents): DO NOT DIAGNOSE WITH A1C. For children/adolescents with polyuria/polydipsia, immediately dip urine for glucose or do meter reading (due to risk of DKA). If urine positive for glucose, or capillary blood glucose > 11 mmol/L, refer to pediatrics immediately.

PREDIABETES - IMPAIRED FASTING GLUCOSE (IFG) & IMPAIRED GLUCOSE TOLERANCE (IGT):

- IFG = FPG of 6.1 – 6.9 mmol/L.
- IGT = FPG of < 6.1 mmol/L and a 2-hr (post 75g glucose load) PG of 7.8 mmol/L - 11.0 mmol/L.
- IFG & IGT = FPG of 6.1 – 6.9 mmol/L and a 2-hr (post 75g glucose load) PG of 7.8 mmol/L - 11.0 mmol/L.
- Prediabetes: A1C 6.0 - 6.4% (see cautions/limitations above—point 4)

Interventions: Lifestyle modifications; annual rescreening.

PREGNANT POPULATION – SCREEN HIGH RISK PATIENTS AS EARLY IN THE PREGNANCY AS POSSIBLE. SCREEN ALL BETWEEN 24 & 28 WEEKS (CLOSER TO 24):

1. **Screen** at 24 to 28 weeks gestation. Administer a 50g oral glucose challenge (1st trimester in high-risk patients). PG is drawn at 1-hr pc.
If the 1-hr PG is:
- 7.8 - 11.0 mmol/L, a 75g OGTT is recommended.
- ≥ 11.1 mmol/L, GDM is present and the 75g OGTT is not necessary and contraindicated.

2. **Following an abnormal screen** (7.8 – 11.0 mmol/L), administer a 2-hr 75g OGTT. Proper preparation is needed for the OGTT (fasting with usual/normal CHO intake for 3 days prior). PG is drawn fasting, at 1-hr, and at 2-hrs pc for the 75g.
- Diagnostic for **GDM** following a 75g OGTT (**one or more values** are equal to or exceed [≥] the following):
  FPG: ≥ 5.3 mmol/L **1-hr PG: ≥ 10.6 mmol/L** **2-hr PG: ≥ 9.0 mmol/L**

RECOMMENDED TARGETS FOR DIABETES CONTROL:

These are the recommended targets for individuals with DM; if not achieved, treatment should be initiated or changed per the CDA 2013 Clinical Practice Guidelines.

Glycated Hemoglobin (A1C): Measure q 3 months (q 6 months if at glycemic target, in stable condition, and with no treatment changes).
- Individualize. For **most** individuals with type 1 or 2 DM, ≤ 7.0%; children up to 8%; less stringent (7.1% to 8.5%) for those with limited life expectancy, multiple morbidities, risk of severe hypoglycemia/hypoglycemia unawareness, extensive cardiovascular disease, individual patient considerations, etc. If it can **be safely achieved,** lower toward normal (≤ 6.5%) for **some** with type 2 DM.

Blood glucose: Optimal glucose control in non-pregnant adults and children over age 12 years:
- Fasting or preprandial PG: 4-7 mmol/L
- 2-hr PG: 5-10 mmol/L

Lipids: Measure fasting at diagnosis, or by age 12, and yearly as clinically indicated. More frequent testing is required in the presence of lipid-lowering therapy.
- LDL-C: ≤ 2.0 mmol/L or 50% reduction
- apo B (optional): < 0.8 g/L or non-HDL-C ≤ 2.6 mmol/L

Blood pressure (BP): Measure at diagnosis and every visit thereafter.
- For most, < 140/80 mmHg or < 90th %ile for age, gender, and height in children. < 130/80 may be appropriate for those with evidence of kidney damage and if safely achieved without undue burden.

Kidney Function: Annual (after 5 yrs and puberty in type 1 DM) random albumin to creatinine ratio (ACR); and in adults (≥ age 19), serum creatinine (for eGFR).
- ACR: < 2.0 mg/mmol
- eGFR: ≥ 60 mL/min

MANAGEMENT AND SURVEILLANCE RECOMMENDATIONS:

- DM self-management education (knowledge, skills, and behavioral--including problem-solving and goal setting). Timely initial education and ongoing support.
- Routine foot and eye examinations. Annual foot examination (including structural abnormalities, evaluation for neuropathy [10g monofilament testing] and PAD); eye examination through dilated pupils every 1 to 2 years (free annual eye exam in NS for persons with diabetes--optometrist/ophthalmologist).
- Individualize self-monitoring of blood glucose (SMBG). For individuals using insulin more than 1x/day, SMBG is an essential part of DM self-management. Encourage interpretation and action. For non-insulin using individuals who are well managed, routine SMBG is not required. Individualize frequency of testing depending on antihyperglycemic agent, risk of hypoglycemia, and ability to interpret and adjust treatment.
- Annual influenza vaccine. Consider immunization against pneumococcus (a 1-time revaccination is recommended for those > 65 years of age if the original was when < 65 years, with at least 5 years between administrations).
- ASA treatment should **not** routinely be used for primary prevention. Consider 80-325 mg in people with established CVD.
- Screen regularly for subclinical diabetes distress, adjustment problems, anxiety, psychiatric disorders, and eating disorders.
- Baseline resting ECG in all individuals > age 40; all individuals with duration of DM > 15 yrs and age > 30; with end organ disease; with cardiac risk factors. Repeat ECG stress testing every 2 years.

LIFESTYLE MODIFICATIONS:

- Smoking prevention/cessation
- Healthy eating
- Weight management (BMI 18.5 to 24.9)
- Physical activity (aerobic ≥ 150 mins/wk; and resistance, 3 sessions/wk)
- Waist circumference: men < 102 cm; women < 88 cm

Reference: Canadian Diabetes Association Clinical Practice Guidelines Expert Committee. Canadian Diabetes Association 2013 clinical practice guidelines for the prevention and management of diabetes in Canada. *Can J Diabetes*. 2013;37(suppl 1):S1-S212. Available at: guidelines.diabetes.ca.