DCPNS TRANSITION CONSULTANT REFERRAL FORM

Instructions (if completing by hand, please print):
Please forward completed Referral Form as well as the Consent Form to the Transition Project Consultant (contact information noted below). **To ensure confidentiality, please fax or forward using SEND (send.nshealth.ca).**

Patient Information

Name: _____ Type of Diabetes: _____

Phone: Home: _____ Cell: _____ E-mail: _____

Preferred method of contact: ☐ Phone Call ☐ Text Permission to leave a voice message: ☐ Yes ☐ No

Transfer Date (last date at pediatric site): _____ Appointment Date (adult site/specialist): _____

Reason for Referral:

- ☐ Family/individual circumstances (identified challenges)
- ☐ History of recurrent adverse glycemic events (DKA and Severe Hypoglycemia)
- ☐ Overall poor or deteriorating diabetes control
- ☐ Patient/Family articulated concerns/fears
- ☐ Team decision/assessment, in conjunction with the young adult re: shared concerns
- ☐ Consent signed with copy attached

Specific Request:

_____

_____

_____

_____

Referral Site Information

Referring Diabetes Centre: _____

Key Contact/Designate: _____ Referral Date: _____

Phone: _____ E-mail: _____

Transition Project Consultant
Diabetes Care Program of Nova Scotia
Fax: 902-473-3911; Phone: 902-473-3208 ; Email: transition@dcpns.nshealth.ca