Appletree
Medical Group

Diabetes Program Consultation Request

Date of Referral: _____

Address: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

Date of Birth: _____

Health Card # _____ Version Code: _____

Referring Physician

Name: _____ Provider Number: _____

Telephone: _____ Fax: _____

Diagnosis/Reason for Referral

Please see this patient in consultation regarding Type II Diabetes.

****IN PREPARATION FOR THE VISIT, PLEASE ORDER OR ATTACH THE FOLLOWING LAB TESTS****
Fasting Glucose, HbA1C, Lipid Assessment, Creatinine, Urinalysis, TSH, Uric Acid, Sodium, Potassium, CK, ALT, Albumin, CBC

Other Pertinent Information (including medications)

Referring Physician's Signature: _____