

## Client Self-Referral Niagara Diabetes Centre

**Fax Referral To: 905-682-3622**

**Phone: 905-682-4200 or 1-800-263-2480**

**Appointment Location:**  St. Catharines  Niagara Falls  Welland

Last Name (please print)		First Name (please print)	
Birth Date (dd/mm/yyyy)		Age	Gender
Address			
City		Province	Postal Code
Home Telephone Number:		Cell Phone Number:	
Work/Business Number:		Health Card Number:	

**Reason for Referral:**  Education  Management Control  Other: \_\_\_\_\_

**Please indicate your current and/or past medical history:**

Pre-Diabetes/Date of Diagnosis \_\_\_\_\_  Type 2 Diabetes/Date of Diagnosis \_\_\_\_\_  
(dd/mm/yyyy) (dd/mm/yyyy)

Type 1 Diabetes/Date of Diagnosis \_\_\_\_\_  At Risk for Diabetes \_\_\_\_\_  
(dd/mm/yyyy)

Heart Disease  High Blood Pressure  Renal/Kidney Disease  Other: \_\_\_\_\_

List any medications that you take for Diabetes:

--	--

Family Physician Name (optional)	Office Number
Address	
Client Signature	Date (dd/mm/yyyy)

