**HOME AND COMMUNITY CARE SUPPORT SERVICES**
South West

Fax: 519-657-4578
1-844-800-4758

# Type 1 Diabetes Request for Treatment

**REQUEST AND TREATMENT ORDER FORM**

DIAGNOSIS : Type 1 Diabetes

Planned Start Date :

Client Name:_____
Contact Name:_____
Address:_____
Phone:_____
DOB:_____
HCN_____
School:_____

OHIP Billing K070

**REASON FOR REFERRAL:**

Child/teen requires school support over the **lunch hour** with:

☐ insulin administration
☐ blood glucose monitoring

Timing: _____

Child/teen and family to return to Children's Hospital for ongoing diabetes education and support.

If questions or concerns, please contact the appropriate diabetes team member at (519) **685 – 8500.**

**CLIENT AWARE OF REFERRAL ?** ☐ **Yes** ☐ **No**

**Signature _____ Date _____**

Paediatric Endocrinologist (519) 685-8500

☐ Dr. Clarson ext 52450
☐ Dr. Stein ext 58139
☐ Dr. Gallego ext 58139
☐ Dr. Sottosanti ext 58139

Physicians Signature _____
Date _____
Physician Signature for orders required under Regulated Health Professional Act.

Home Medication List

Family/RN/RPN is able to adjust insulin by 20% as per physician's order