

**Telephone-Based Education and Self-Management Support for Adults with Diabetes and/or Heart Failure in Manitoba**

Please complete all fields on the referral form and **fax to 204-779-5645**

- PRE-DIABETES**
- TYPE 2 DIABETES** ( Diagnosed with Type 2 Diabetes and not pregnant)
- HEART FAILURE** (Diagnosis of heart failure)

***Patient Demographic Information:***

Last Name: _____	First Name: _____	M__F__
Date of Birth: (day/mo/yr.) _____	P.H.I.N. _____	
Mailing Address: _____		
Phone Numbers: Home _____	Other _____	
Does client consent to messages being left at above numbers? Yes___ No___		
Is client aware of referral? Yes___ No___		

***Referring Information:***

**Date of Referral:** \_\_\_\_\_

Referred by: _____	Title: _____	Phone: _____
PCP Name: _____		Phone: _____
PCP Address: _____		Fax: _____

***Health Information:***

<b>HbA1C:</b> _____ %	Date: _____
<b>Lipid Profile:</b> Total Chol _____ HDL _____ LDL _____ Trig _____ Ratio _____	Date: _____
<b>Ejection Fraction:</b> _____ %	Date: _____ (for the Heart Failure Program)
<b>Height:</b> _____ in _____ cm, <b>Weight:</b> _____ lbs. _____ kg, <b>BP:</b> _____	Date: _____

***Medical History and Medications:*** (Please attach any relevant information)

_____ _____ _____ <b>ACTION PLAN FOR HIGH BLOOD SUGAR or other acute symptoms:</b> _____ _____ _____
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**For further program information call 204-788-8688, or toll-free 1-866-204-3737.**

**Referral forms and more information are available at:**

[www.gov.mb.ca/health/phc/telecare](http://www.gov.mb.ca/health/phc/telecare)