LMC DIABETES & ENDOCRINOLOGY

Diabetes Education Program
OTN Patient Referral Form

○ English ○ French

PATIENT INFORMATION:

Name: _____ **DOB:** _____
(first name) (last name) (dd/mm/yyyy)

Health Card: _____ **Version Code:** _____ **Uninsured Specify:** _____

Address: _____
(number) (street name) (unit)

_____
(city) (postal code) (e-mail address)

_____
(home #) (work # with extension) (other #)

PLEASE SPECIFY:	**PLEASE SPECIFY CLASS:**
○ **Type 2 Diabetes**	○ **DM 101 Workshop**
○ **Pre-Diabetes**	○ **DM 102 Workshop**

Notes:

_____

_____

_____

Referred By: **Referring Physician Billing #:**

Referring Physician Signature:

Patient OTN Site& Number: _____

OTN Location: **Date:** _____

Send Referrals To:

F: 1.877.LMC.APPT (562.2778)
E: referrals@lmc.ca