



Aurora Holistic Solutions - Referral Form
EMAIL REFERRALS TO: info@auroraholistic.ca

TEL: 613-601-9950 | 613-822-2840 | www.auroraholistic.ca
Suite 9, 2401 Bank St, Ottawa, ON K1V 8R9
(Children <= 17 years diagnosed with diabetes: refer immediately to CHEO 613-737-7600 *0 and ask for diabetes physician on call)

CLIENT LAST NAME: _____

CLIENT FIRST NAME(S): _____

GENDER: ☐ M ☐ F ☐ Other: _____ DOB: _____ / _____ / _____
(YYYY) (MM) (DD)

☐ INDIGENOUS ☐ CURRENTLY PREGNANT

ADDRESS: _____
(#, Street, Apartment, City, Province, Postal Code)

TELEPHONE #: () _____ OTHER #: () _____ Alternate Contact person: _____

CLIENT PREFERS SERVICES CLOSER TO ☐ Home **OR** ☐ Work/Other (provide location): _____

DIAGNOSIS: ☐ Prediabetes **or** ☐ Type 2 Diabetes

DURATION OF DX: ☐ New Dx ☐ 1-5 yrs ☐ 5+ yrs

PREFERRED LANGUAGE OF SERVICE:

☐ English ☐ French ☐ *Other: _____
☐ Interpreter required (check box) (*specify language)

Please note: Aurora Holistic does not
provide group education or insulin initiation to clients with Type 1 Diabetes.

☐ Type 1 Diabetes

Question for Type 1 Diabetes: Is client seen by a diabetes specialist? ☐ Y ☐ N

If yes, please provide name of specialist: _____

SERVICES REQUESTED / MAIN REASON FOR REFERRAL

☐ Diabetes Education and Support

Appropriate for Group? ☐ Y ☐ N _____

☐ *Insulin Initiation ☐ *Insulin and/or Medication Adjustment

***Please attach labs and complete orders below.**

MEDICAL HISTORY / RISK FACTORS ☐ Attached

RECENT LAB RESULTS ☐ Attached (HbA1c, FBG, eGFR, ACR, Lipids)

CHALLENGES THAT MAY IMPACT LEARNING OR SERVICES REQUESTED

☐ cognitive impairment

☐ developmental challenges

☐ non-insured

☐ no MD/NP

☐ mobility issues

☐ problematic drug/alcohol use

☐ homeless/marginal housing

☐ literacy

☐ mental health challenges: _____

☐ other: _____

CURRENT MEDICATIONS ☐ Attached (name/dose/frequency)

INSULIN INITIATION* Insulin type: _____ Dose / Time: _____

Titration Orders: Increase by _____ unit(s) at _____ (time) every _____ (night/day)

until _____ (am/pm/hs) readings are consistently under _____ (glycemic targets).

Discontinue Oral Medication(s)? ☐ N ☐ Y (Specify): _____

INSULIN ADJUSTMENT* (Must be completed to allow educator to teach insulin dose adjustment)

Insulin type: _____ Dose: _____ Insulin type: _____ Dose: _____

☐ Check box to allow Diabetes Educator to teach insulin dose adjustment by 1-2 units/up to 10% daily insulin dose

*Physician / NP Signature required for Insulin or GLP-1 Orders above: _____

(PLEASE SIGN HERE ↑)

GLP - 1 INITIATION / ADJUSTMENT*

Type: _____

Dose: _____ Time: _____

Titration Orders:

ADDITIONAL COMMENTS / SPECIAL INSTRUCTIONS

REFERRING PROVIDER (or Stamp)

Name:

Address:

Phone:

Fax: