McMaster Pediatric Diabetes
Outpatient Clinic Referral form

Dear Referring Practitioner,

Thank you for your referral. In our efforts to minimize wait times and optimize your patient's initial visit with us, we kindly ask that review the guidelines listed below.

Please note the following:

Suspected or Confirmed New Onset Diabetes Mellitus, type 1: Please contact the Pediatric Endocrinologist on On-Call (905) 521-5030 for any symptomatic child with *glycosuria* or *ketonuria* for ***immediate*** referral; the child should also be sent to the Emergency Department.

Suspected or Confirmed New Onset Diabetes Mellitus, type 2: If the patient has *ketonuria*, send to the Emergency department and contact the Pediatric Endocrinologist on On-Call (905) 521-5030 for an ***immediate*** referral.

For a child with established Diabetes on treatment or if a 2 hour OGTT if suspicious for Type 2 Diabetes Complete the McMaster Children's Hospital Pediatric Diabetes Program Referral Form located on our website.

Hyperlipidemia: Please refer directly to the Pediatric Lipid Clinic (Fax 905-385-5033)

Hypertension: Please refer directly to the Pediatric Nephrology Clinic (Fax 905-521-5056)

Obesity: Please refer directly to Children's Exercise and Nutrition Clinic (Fax 905-385-5033)

Sincerely,

McMaster Pediatric Endocrinology and Diabetes Team

Guidelines for Referral to Tertiary Centre

Please consider consultation with your tertiary centre if you observe any of the following:

- The classification of a child's diabetes as Type 1, Type 2, Monogenetic or other forms of diabetes is uncertain. The possibility of other types of diabetes should be considered in a child who has:
    - An autosomal dominant family history of diabetes
    - Diabetes diagnosed in the first 6 months of life
    - Mild fasting hyperglycemia (5.5-8.5 mmol) that does not progress
    - Associated health concerns such as deafness, optic atrophy, syndromic features
    - History of exposure to drugs known to be toxic to β cells or cause insulin resistance
- A child has a persistently elevated A1C >10% (i.e. 2 or more consecutive A1c values above 10% over 6-12 months). *According to the 2013 Canadian Diabetes Association Clinical Practice Guidelines (Wherrett et al 2013), children with persistently poor glycemic control i.e. A1C >10% should be assessed by a specialized paediatric diabetes team for a comprehensive interdisciplinary assessment and referred for psychosocial support as indicated.*
- A child experiences recurrent admissions for DKA (i.e. 2 or more episodes of DKA within 1 year).
- A child experiences recurrent severe hypoglycemia requiring glucagon or hospitalization (i.e. 2 or more episodes of severe hypoglycemia within 1 year).
- A child develops diabetes related vascular complications (persistent microalbuminuria, neuropathy, retinopathy or macrovascular disease).
- A child and their caregivers would benefit from professional services unavailable at your centre (i.e. Child Life Specialist, Endocrinologist, Adolescent Medicine, and/or Mental Health Specialist).
- A child and their caregivers would benefit from a comprehensive interdisciplinary assessment and recommendations to improve metabolic control.
- A parent/caregiver or youth requests a consultation with the tertiary centre.

Please note: The above is not an exhaustive list of consultation scenarios. Please contact us directly if you wish to speak to a member of the McMaster Children's Hospital Pediatric Diabetes Team about a potential consultation request. For more detailed information about our team members and referral process, please visit our website.
http://mcmasterchildrenshospital.ca/body.cfm?id=58

October 2016

McMaster Children's Hospital

McMaster Children's Hospital
Pediatric Diabetes Program Referral Form

2G Clinic Fax 905-521-5056

☐ **Consult Only** ☐ **Consult and Time Limited Follow up** ☐ **Consult and Share Care** ☐ **Consult and Transfer Care**

Patient Name:_____

DOB:___/___/___ __Male __Female
DD MM YY

Health Card # _____(OHIP)

Address:_____

_____ Postal Code:_____

Telephone: (Res)_____
(Bus)_____
(Cell) _____

Family Physician _____

Parent/guardian Names: _____

_____

Telephone # (Res)_____
(Bus)_____
(Cell) _____

Who does the patient Reside with?

☐ Both Parents ☐ Mother ☐ Father ☐ Guardians

Custody? ☐ Mother ☐ Father ☐ Joint Other _____

CAS/FACS involvement? ☐ Yes ☐ No

Diabetes Diagnosis: ☐ Type 1
☐ Type 2
☐ Other _____
☐ Uncertain

Treatment: ☐ Lifestyle ☐ OHA ☐ Injections ☐ Insulin Pump

Most recent HbA1c _____% Date _____
_____% Date _____

Diabetic Ketoacidosis Date _____

Severe Hypoglycemia Date _____

Reason for Consultation:

☐ Diagnosis Uncertain ☐ Persistently Elevated HbA1c ☐ Recurrent DKA

☐ Recurrent Severe Hypoglycemia ☐ Request for Professional Services or Interdisciplinary Assessment

☐ Diabetes related vascular complications ☐ Child/Parent/Caregiver Requests Consultation ☐ Other

Details of Referral: _____
_____
_____
_____
_____
_____

Referring Physician Name _____ **Date of Referral** _____

Physician Signature _____ **Billing Number** _____