The SunLife Lifestyle Management Program for Children with or at Risk for Diabetes

Pediatrician, Physician or Allied Health Professional Referral

Referring Health Professional Information

Name:_____
(Please Print)
Address:_____

_____

Phone:_____

Fax:_____

Patient Information

Name:_____
(Please Print)
DOB:_____Age:____M ☐ ☐

Address:_____

_____

Parent/Guardian(s):_____

Phone: (h)_____(c)_____

Family has been made aware and is in agreement of this referral YES ☐ NO ☐

Reason for Referral:

Relevant Medical History (Please include most recent lab work):

Medications:

Allergies:

Physician Signature:_____ **Date:**_____

Dr. Paul Schwann Centre Clinic Use Only **Group 1** ☐ **Group 2** ☐ **Group 3** ☐ **Group 4** ☐ **Group 5** ☐

Referral Received by:_____**Date:**_____**(dd/mm/yr)**

**PLEASE COMPLETE REFERRAL AND RETURN BY FAX TO (306) 585-5363