youville
Diabetes Centre

33 rue Marion Street Winnipeg, MB R2H 0S8
Tel/Tél: (204) 233-0262
Fax/Téléc: (204) 233-1520
Website: www.youville.ca

Thank you for making a referral to Youville Diabetes Centre (YDC) for diabetes self-management education and support (DSMES). Your patients are important to us, and we want to ensure that they receive the **appropriate** care in a timely manner.

Our centre provides the following services/supports for those living with prediabetes or diabetes:

- Individual and/or group diabetes self-management education and skill building
- Problem solving and decision-making support regarding diabetes management
- Collaboration with other services and healthcare providers
- System navigation & advocacy
- Counseling and Social Work support
- Community food pantry

Our team at YDC consists of diabetes nurse and dietitian educators, counsellors, and social workers who are committed to working collaboratively with the people we serve and their circles of care, to assist people we serve in building their capacity to live well with diabetes, and prediabetes, and prevent complications.

We do not have a physician on site as a part of our program, therefore, we are limited in the amount of medical management and support we provide.

As an organization, we prioritize Indigenous peoples, newcomers, and people who experience systemic barriers and the greatest health inequalities (I.e. 2SLGBTQIA, visible minorities, and individuals subjected to complex poverty).*

Eligibility:

- Adult over the age of 18
- Diagnosed with (one of):
  - Gestational diabetes
  - Prediabetes
  - Type 1 diabetes
  - Type 2 diabetes
- Are ready to engage in diabetes self-management education and support
- Patient must be made aware of their diagnosis and referral prior to this referral being sent

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Please fax referral form to 204-233-1520

Referral information:

Last Name: ______________________________
Name: ___________________________________
Preferred name: _________________________
Address: ________________________________
____
Postal Code: ____________________________
Tel: (H) ______________(W) ______________
(C) ____________________________________

D.O.B: (d/m/y) ________/ ________/ ________
Gender: M F Other
Email: __________________________________
MH No: __________________________________
PHIN: ___________________________________

Physician/NP/PCP Name:
____

Address: ________________________________
____
Postal Code: ____________________________
Telephone: ______________________________
Fax: ____________________________________

Interpreter Required: ☐ Yes ☐ No

Preferred Language: _____________________

The patient is: Indigenous, newcomer, experiences systemic barriers (I.e. 2SLGBTQIA*, visible minorities, or subjected to complex poverty). ☐ Yes ☐ No

Type of Diabetes (*Must complete): ☐ Prediabetes ☐ Type 1 ☐ Type 2

☐ Gestational Diabetes- EDC ______________________

Duration of Diabetes: _________________________

Primary Reason for Referral:

☐ Medication education and skill building

☐ Healthy eating education and skill building

☐ Monitor education and skill building

☐ Coping and stress/diabetes distress management

☐ Physical activity education and capacity building

☐ Reducing risk – managing acute and chronic complications

☐ Counseling or Social Work support

Additional information: ____
____
____

REQUIRED: I have explained this referral and the individual agrees to participate in diabetes self-management and are aware of the diagnosis and disclosures on this referral.

Physician/NP/PCP Signature: ______________________________Date: ______________________