West Toronto Diabetes Education Program

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Phone: 416-252-1928
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CLINIC USE ONLY

Date Received: _____
(dd/mm/yyyy)

Appointment Date: _____
(dd/mm/yyyy)

Client Information

Last Name: _____ First Name: _____

Date of Birth (dd/mm/yyyy): _____ OHIP#: _____ (_____)

I identify my gender as: ❑Female ❑Intersex ❑Male ❑Trans Female to Male
❑ Trans Male to Female ❑Two-Spirit ❑Other (Please Specify) _____

Address: _____

City: _____ Postal Code: _____

Home Number: _____ Cell Number: _____

Email address (optional): _____

I allow West Toronto DEP to contact me via email regarding updates and upcoming events? ❑Yes ❑No

Best time to contact you? ❑ am ❑ pm

Primary Language: ❑English ❑Other_____ Interpreter Needed? ❑Yes ❑No

Health Information

What type of diabetes are you living with? ❑ At risk ❑ Pre-diabetes ❑ Type 2

How do you manage your diabetes? ❑ Diet/Exercise ❑ Oral Medication ❑ Insulin

How long have you lived with diabetes? _____

Type of service requested: ❑ Individual counseling ❑ Group Education Session ❑ Physical Activity

What would you like to learn about? (Check all that apply)

❑ Physical Activity
❑ Meal Planning
❑ Label Reading
❑ Weight Management
❑ Glucometer Reading
❑ High and Low Blood Sugars
❑ Smoking Cessation
❑ Other: _____
❑ Medication/Insulin
❑ Stress Management
❑ Complications

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