LMC Diabetes & Endocrinology

Patient Referral Form

○ Barrie   ○ Brampton   ○ Etobicoke   ● Mid-Toronto   ○ Oakville   ○ Scarborough   ○ Vaughan

PATIENT INFORMATION:

Name: Andreia Da Silva (first name)   Muniz Campelo (last name)   **DOB:** 17/10/1975 (dd/mm/yyyy)

Health Card: ON 6293 643 067   **Version Code:** TF   **Uninsured Specify:**

Address: 1415 Lawrence Ave Unit 218 (number) (street name) (unit)

Toronto (city)   M6L 1A9 (postal code)   andreiacampelo@hotmail.com (e-mail address)

(home #)   (work # with extension)   437-775-7830 (other #)

● Consultation & shared care   ○ Consultation only   ○ Diabetes Education only

○ Chiropody Assessment   ○ Optometry Consultation

DIABETES/ENDOCRINOLOGY PLEASE SPECIFY:

The following investigations would be helpful:

○ Diabetes ○ Type 1 ○ Type 2 ○ GDM	○ FPG, A1C, Lipids, Renal Function, uACR
○ Newly Diagnosed Diabetes Rapid Triage (1-2 weeks)	○ FPG, A1C, Lipids, Renal Function, uACR

○ Thyroid	○ Thyroid function, Relevant imaging
○ Osteoporosis	○ BMD report <2 years, other relevant labs
○ Lipids	○ TC, LDL, HDL (<3 months), A1C
● PCOS	○ LH, FSH, estrogen, testosterone, A1C
● Other (please specify): weight loss	

Notes:

Please assess this pt re; possible use of GLP-1 RA such as ozempic for wt loss. Pt was previously diagnosed with PCOS and was put to metformin (no longer on it). Pt wishes to use ozempic or mounjaro to lose weight however pt is trying actively to get pregnant and will be going through IVF next year. Pt would like to speak to Endo re; safety and etc. Thank you.

Current Medications:

Referred By: Edward Lee
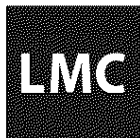
Referring Physician Billing #: 021921

Referring Physician Signature:
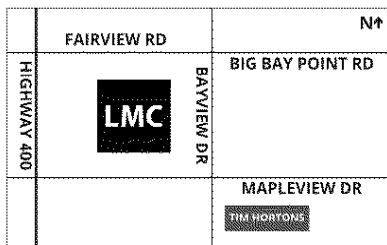
Date: 23/10/2025

New Patient Referrals: **T:** 1.866.701.ENDO (3636)   **F:** 1.877.LMC.APPT (562.2778)
E: referrals@lmc.ca   **W:** www.LMC.ca/referrals

LMC/PS – V1
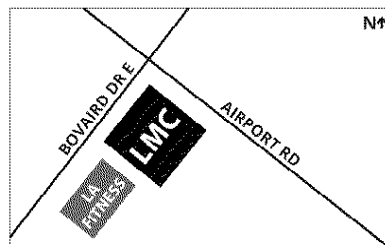
LMC Diabetes & Endocrinology

Our Locations

LMC BARRIE

370 Bayview Drive
Suite 110
Barrie, ON L4N 8Y2
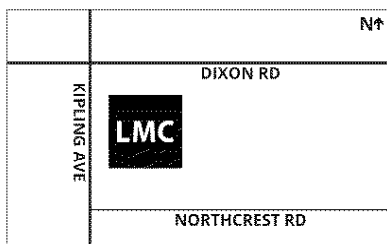
T 705.737.0830
F 1.877.562.2778

LMC BRAMPTON
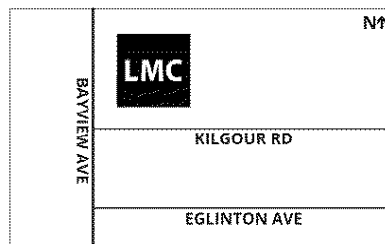
2979 Bovaird Drive E
Brampton, ON L6S 0C6

T 905.595.0560
F 1.877.562.2778

LMC ETOBICOKE

1723 Kipling Avenue
Suite 2B
Etobicoke, ON M9R 4E1

T 416.645.1035
F 1.877.562.2778

LMC MID-TORONTO

1929 Bayview Avenue
Suite 107
Toronto, ON M4G 3E8

T 416.645.2929
F 1.877.562.2778

LMC OAKVILLE

3075 Hospital Gate
Suite 301
Oakville, ON L6M 1M1

T 905.337.0040
F 1.877.562.2778

LMC SCARBOROUGH

520 Ellesmere Road
Suite G125
Scarborough, ON M1R 0B1

T 647.695.3866
F 1.877.562.2778

LMC VAUGHAN

1600 Steeles Avenue W
Unit 5
Vaughan, ON L4K 3B9

T 905.763.8660
F 1.877.562.2778

Muniz Campelo, Andreia Da Silva   **Birth date 17/10/1975   #2876   Page 3/4**

Sep 29, 2025   LifeLabs Medical Laboratories Lab Data   EDLE
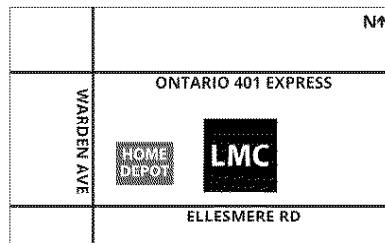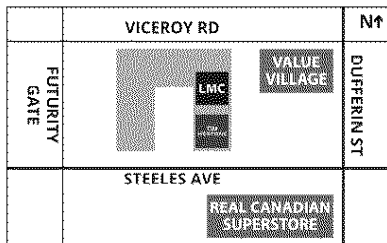
Accession Number   2025-422722195
Collection Date   Sep 29, 2025 4:57PM
Ordering Physician: Lee, Edward
Primary Testing Location:100 INTERNATIONAL BLVD TORONTO M9W 6J6 1(877)849-3637
Client Reference Information:NP

HEMATOLOGY I

WBC	8.4	4.0	- 11.0
RBC	4.11	4.00	- 5.10
Hb	128	120	- 160
Hct	0.384	0.350	- 0.450
MCV	93	80	- 100
MCH	31.1	27.5	33.0
MCHC	333	305	- 360
RDW	12.0	11.5	- 14.5
Platelets	275	150	- 400

HEMATOLOGY II

Neutrophils #	5.0	2.0	- 7.5
Lymphocytes #	2.6	1.0	- 3.5
Monocytes #	0.6	0.2	- 1.0
Eosinophils #	0.2	0.0	- 0.5
Basophils #	0.1	0.0	- 0.2
Immature Granulocytes #	0.0	0.0	- 0.1
Nucleated RBC's	0		

ROUTINE CHEMISTRY I

Hb A1C	5.7	<6.0

Diabetes Canada 2018 Guidelines:

Screening and Diagnosis:
< 5.5 % Normal
5.5% - 5.9 % At risk
6.0% - 6.4 % Prediabetes
>OR= 6.5 % Diabetes Mellitus***

***Regarding diagnosis: in the absence of
symptomatic hyperglycemia, if a single laboratory
test result is in the diabetes range, a repeat
confirmatory laboratory test (FPG, A1C, 2hPG in a
75 g OGTT) must be done on another day for
diagnosis confirmation.

Monitoring: <OR= 7.0 %
Target in adults without comorbidities. Other
targets may be more appropriate in children,
elderly and patients with comorbidities.

Results may not accurately reflect mean blood
glucose in patients with hemoglobin variants,
disorders associated with abnormal erythrocyte
turnover, severe renal and liver disorders.

ROUTINE CHEMISTY RENAL

Cr	71	50	- 100
eGFR	90	SEE BELOW	

Results rule out CKD stage 3-5. Assessment of
urine ACR is required to definitively rule out or
confirm CKD diagnosis. The KidneyWise toolkit
(kidneywise.ca) recommends remeasuring eGFR
and urine ACR annually for people with diabetes
mellitus and less frequently in others unless
clinical circumstances dictate otherwise.

Reference interval: =>60 mL/min/1.73m2

eGFR is calculated using the CKD-EPI 2021

equation which does not use a race-based
adjustment.

LIPID ASSESSMENT

Hours Fasting	1	
TG	2.30 (HI)	

FASTING: <1.70 mmol/L
NON-FASTING: <2.00 mmol/L

CHOL	5.62 (HI)	<5.20

Total cholesterol and HDL-C used for risk
assessment and to calculate non HDL-C.

HDL	1.35	>=1.30

HDL-C <1.30 mmol/L indicates risk for metabolic
syndrome.

LDL	3.34	<3.50

LDL-C is calculated using the NIH equation.

For additional LDL-C and non-HDL-C thresholds
based on risk stratification, refer to 2021 CCS
Guidelines. Can J Cardiol. 2021;37(8):1129-1150.

NON-HDL	4.27 (HI)	<4.20

Non HDL-Cholesterol is not affected by the
fasting status of the patient.

If non-HDL-C >=4.20 mmol/L in primary prevention
setting for low risk patients (FRS 5-9.9%) or
intermediate risk patients (FRS 10-20%), consider
therapy. Therapy also suggested in low risk
patients (FRS <10%) with non-HDL-C >=5.8 mmol/L.

CHOL/HDL	4.2	

Cholesterol/HDL-C is not included in the 2021 CCS
guideline as a lipid initiation or treatment
target but is recognized as an indicator of high
CVD risk at Cholesterol/HDL-C ratio >6.0

ROUTINE CHEMISTRY

ALT	23	<36

SPECIAL CHEMISTRY II

B12	258	>220

>220 pmol/L: Normal, deficiency unlikely
150-220 pmol/L: Borderline,deficiency is possible
<150 pmol/L: Low, consistent with deficiency

SPECIAL CHEMISTRY II

TSH	2.09	0.32 - 4.00

CHEMISTRY

Ferritin	251	

In absence of concomitant inflammation, Ferritin
levels can be interpreted as follows:

30-50 ug/L: Probable iron deficiency
51-100 ug/L: Possible iron deficiency, if risk
factors are present
101-300 ug/L: Iron deficiency unlikely
">600 ug/L: Consider test for iron overload

In patients with concomitant inflammation, use
Iron Studies, including TIBC and Transferrin
Saturation, to assess Iron Deficiency status.

For guidance, see www.hemequity.com/raise-the-bar