Please use ID label or block print

ARMADALE KALAMUNDA GROUP

DIABETES EDUCATION REFERRAL FORM

Family Name:

UMRN:

Given Names:

Gender:

DOB:

Patient Details
Address: ___________________________
___________________________ P/C_______
Phone: Mobile: ____________________
Home: ____________________
Work: ____________________
Aboriginal or TSI: ☐ Yes ☐ No
Interpreter Required: ☐ Yes ☐ No
If yes, which language: _______________

Special Needs
☐ Vision ☐ Hearing
☐ Physical ☐ Cognitive
☐ Language Limitations
☐ Other ___________________________

Referring Doctor.

Name: ____
Address: ____
Phone: ______________________
Fax: ________________________

Reason for Referral

☐ Diabetes Self-Management Education (Diabetes Educator/ Dietitian)
☐ Review of diabetes control (please give clinical details below)
☐ Starting oral hypoglycaemic agents
☐ Starting insulin therapy (please complete Insulin Therapy Order)

Diagnosis
Year of diagnosis: ____________________
Type of Diabetes:
☐ Type 1 ☐ Type 2
☐ Type 2 Insulin Requiring
☐ Gestational diabetes
☐ IFG/ IGT
☐ Other ___________________________

Complications/ Co morbidities
☐ Hypertension
☐ Renal disease
☐ Dyslipidemia
☐ CVD
☐ Neuropathy
☐ Non-healing wound
☐ Mental/ affective disorder
☐ Other ___________________________
____

Physical Activity
☐ Fit for moderate physical activity
☐ Fit for vigorous physical activity
☐ Restrictions on participation: Comment
____

Latest Test Results **Date** ______________ **(or Attach)**
Fasting BGL _______mmol/L Random BGL _______ mmol/L

OGTT results *if applicable*:
Fasting: _______mmol/L 2 hours _______mmol/L

HbA1c ________% BP________mmHg

Cholesterol: ______mmol/L Tryglycerides: _______mmol/L
HDL: ___________mmol/L LDL: _______________mmol/L
Urinary micro albumin: _______

Current Medications (or attach)
Please specify type, dose, frequency for all relevant.
____
____
____
____
____
____

Current Self Care
☐ Self blood glucose monitoring
☐ Registered on NDSS
Patient now uses: ☐ Pen ☐ Syringe ☐ Pump

Patient Lifestyle Goals/ Clinical Targets/ Plan of Care (Attach Care Plan or GP Management Plan if desired)
____
____
____
____
____

Name: ____________________________________**Signature:** ____________________ **Date:** _____________

June 2017

FAX BACK TO (08) 9391 1134

AKMR 60.5 DIABETES EDUCATION REFERRAL FORM