Please use ID label or block print

ARMADALE KALAMUNDA GROUP

INSULIN THERAPY ORDER

FAX TO: 9391 1134

Family Name: UMRN:

Given Names:

Gender: DOB:

Referral to: Date of referral:
Credentialed Diabetes Educator

Surname: First Name:

Address:

Suburb: Post Code:
Home Phone: Business: Mobile:

Date of Birth:

Referring Doctor:
Address:
Suburb:
Post Code:
Business Phone: After Hours: Mobile:
Email:

Type of diabetes: Type 1 ☐ Type 2 ☐ Gestational ☐

Date of Diagnosis:

Laboratory test results: HbA1c: BGL: Ketones:

Current Treatment:

INSULIN THERAPY ORDER

Type of Insulin: Starting dosage: Time and regimen:

_____

Size of incremental adjustment: 2 – 6 Units

Target blood glucose range:
Fasting 4.0 – 7.0mmols/L Post Prandial 6.0 – 10mmols/L

In Type 2 diabetes, is current oral therapy to be continued as combination therapy?
Yes ☐ No ☐

If yes, please state type of oral agent and dosage.
If no, please state which oral agent is to be ceased.

*Case Management For Patient Commencing Insulin Therapy In An Ambulatory Setting

* Please tick appropriate section otherwise referral is INVALID –

☐ The referring doctor wishes the diabetes educator to assist and teach self-management of ongoing insulin dose adjustment by 2-6 units until blood glucose levels are within 4-10mmol/L.

☐ The referring doctor will manage ongoing insulin dose adjustment.

Expectations for progress reports: Weekly ☐ Fortnightly ☐ 3 Monthly ☐

Signature and Stamp:

Sept 2014

AKMR 60.6 INSULIN THERAPY ORDER