**Patient Details**

Name

DOB Gender M F

Address

Postcode

Ph: ..... Mobile: .....

**Referral to:**

**Ambulatory Insulin Stabilisation Service**

- ☐ Gympie
- ☐ Nambour
- ☐ Caloundra

*Referral from Shared Care Community Clinic, SCCC*

Reason for Ambulatory Stabilisation Referral

- ☐ Type 1 diabetes with sub-optimal control
- ☐ Type 2 diabetes requiring initiation of insulin
- ☐ Type 2 diabetes; insulin initiated in SCCC (details below)
- ☐ Newly diagnosed Type 1 diabetes
- ☐ Other: .....

***Enquiries regarding referral process please phone Nurse Manager Diabetes Service 54705088***

**Insulin Initiated**

Type: .....

Starting dose: .....

Date commenced: .....

Commenced By: ☐ Referring GP
☐ Diabetes Specialist
☐ .....

**Current Other Medications**

**Allergies:**

**Special Circumstances:**

**RELEVANT Psychosocial issues**

**REQUIRED Investigations**

| Investigations | Attached | Requested |
|---|---|---|
| HbA1c | | |
| FBC | | |
| Lipid panel | | |
| TSH | | |
| Urine AER/MA | | |
| E/LFT | | |
| Vitamin B12 | | |

***Please attach copies of appropriate results***

**If requested which provider used? (circle one)**

| QML | S&N | Gribbles | Coastal |
|---|---|---|---|

**GP Care Plan Completed** ☐ Y *please attach* ☐No

**Smoker** ☐ Y ☐N ☐Ex-smoker

**Alcohol** ☐ Y standard drinks/week ☐N

**GP/Practice Stamp:**

**Provider Number**

**GP Signature** **Date**

Central Referral Centre
Specialist Outpatients Department
PO Box 547,NAMBOUR QLD 4560
**Fax: 07 5470 6377**