**Patient Details**

**Name** _____

**DOB** _____ **Gender** **M** **F**

**Address** _____

_____

_____**POSTCODE**_____

**PH** **MOB**

**Diabetes Referral To:**

☐ Dr Shyam Sunder – 5470 5088

☐ Dr Steven Hamwood – 5470 5088

☐ Credentialled Diabetes Educator – 5470 5088

☐ _____

**Reason for referral to Specialist (please refer to clinical guidelines)**

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Diabetes in Pregnancy ☐ Other (please specify)

_____

_____

_____

_____

**Reason for referral to Credentialed Diabetes Educator (please tick)**

☐ Group Education ☐ High risk feet ☐ Insulin pump review clinic

☐ Gestational diabetes education ☐ Insulin stabilisation/initiation ☐ Insulin pump education

☐ Multiple risk factors ☐ Other –(please specify)_____

_____

***Enquiries regarding referral process please phone Manager Diabetes Service 5470 5088***

**REQUIRED Investigations:**

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

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

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

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

**Allergies**

_____

_____

_____

**GP Care Plan Completed** ☐ Y please attach ☐ N

**Smoker** ☐ Y ☐ N ☐ Ex - smoker

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

**Special Circumstances**

_____

_____

_____

**RELEVANT Psychosocial issues**

_____

_____

_____

**CURRENT Medications**

_____

_____

_____

_____

_____

**GP/Practice Stamp:**

**Provider Number**

**GP Signature** **Date**

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