PERTH **DIABETES** CARE

SPECIALISING IN DIABETES CARE AND ALLIED HEALTH SERVICES

Perth Diabetes Care Teen & Young Adult Type 1 Diabetes Clinic

Referral To
Perth Diabetes Care
968b Albany Hwy,
East Vic. Park WA 6101
P: (08) 6110 0570
F: (08) 9355 5718
E: admin@perthdiabetescare.com.au
Please return referral by fax or email

Clinic Location

Telethon Type 1 Diabetes Family Centre

11 Limosa Court, Stirling, WA, 6021

Referring Doctor Details (Stamp)
Name:
Address:

Phone No:
Fax No:
Provider No:

Patient Details
Name:________________________________

Address:________________________________

____

Ph:________________ **Mob:** ________________

DOB:______________________ **Gender**: M / F

Aboriginal or Torres Strait Islander: Yes / No

Medicare #:______________ ( ) **Exp:**____________

Concession card holder: Yes No
Registered with NDSS: Yes No
Current Endocrinologist:

Reason for referral
- ☐ Newly Diagnosed
- ☐ Education Review
- ☐ New to Insulin (Insulin titration order required)
- ☐ Insulin Titration (Insulin titration order required)
- ☐ Considering Insulin Pump
- ☐ Insulin Pump Refresher/Fine Tuning
- ☐ Continuous Blood Glucose Monitoring
- ☐ Carbohydrate Counting
- ☐ Weight management / Diet Review
- ☐ Exercise support
- ☐ Family Counselling
- ☐ Individual counselling
- ☐ Other:____________________________

Medical Conditions
- ☐ Type 1 Diabetes,

Date of Diagnosis (if known):____________________
- ☐ Type 1 Diabetes with pregnancy
- ☐ Type 1 Diabetes planning pregnancy
- ☐ Other:______________________________

Referral to:
- ☐ Credentialled Diabetes Educator
- ☐ Accredited Practising Dietitian
- ☐ Counsellor
- ☐ Exercise Physiologist

Please attach the following (if applicable)
- **Recent relevant pathology results**
- **Insulin Stabilisation form** (please see overleaf)
- **GP Management Plan (MBS Item 721)**
- **Team Care Arrangement (MBS Item 723)**
- **Medicare Referral Form for Individual Allied Health Services (MBS Item 10950 - 10970)**

GP or Endocrinologist & Patient Consent
My GP or Endocrinologist has explained the purpose of this referral and I give permission to provide and discuss my medical information with other service providers who are contributing to my care. I understand that my medical information will remain confidential. I am aware I will be required to attend a Perth Diabetes Care Clinic location for my appointment. I am aware that I may request a copy of the Perth Diabetes Care Pty Ltd Privacy and Confidentiality statement at any time. I can withdraw at any time. I am aware there may be some costs involved for these services.

Referrers signature:____________________________ **Date:**______________

Patient signature:____________________________ **Date:**______________

Insulin Stabilisation Order

admin@perthdiabetescare.com.au
Office: 08 6110 0570 | Fax: 08 9355 5718
968b Albany Hwy, East Vic Park, WA 6101
www.perthdiabetescare.com.au

PERTH DIABETES CARE
SPECIALISING IN DIABETES CARE AND ALLIED HEALTH SERVICES

Referral to Perth Diabetes Care Credentialled Diabetes Educator

Patient Name: ____________________

Date of Birth: ____________________

Referring Doctor: (Stamp)

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

Date of Diagnosis: ____________________

Current Insulin Administration Method: ☐ Injections ☐ Pump ☐ Currently using CGMS

Insulin Therapy Order

Type of Insulin	Starting Dosage	Time of Administration (mane, midday or nocte)	Frequency (once, twice, three times daily)
Toujeo			
Lantus			
Levemir			
Novorapid			
Apidra			
Humalog			
Actrapid			
Novomix 30			
Other:			

Target Blood Glucose Range

Fasting	Pre Prandial	Post Prandial	Before Bed	Other

Size of unit adjustement Eg: 2 units	
Adjust Every	____________ day(s) or ____________ week(s)

Recent Ketoacidosis	☐ Yes ☐ No	Recent Hospitalisation	☐ Yes ☐ No
Recent Severe Hypoglyceamia	☐ Yes ☐ No	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 to continue	
If no, please state which oral agent is to be ceased	

Case Management For Patient Using Insulin Therapy

Please tick appropriate section(s) otherwise referral is INVALID

The referring doctor wishes the Credentialled diabetes educator to assist and teach self-management of ongoing insulin dose adjustment as indicated above.	☐ Yes ☐ No
The referring doctor wishes the Credentialled diabetes educator reduce the patients insulin dosage accordingly to avoid hypoglycaemia.	☐ Yes ☐ No
The referring doctor wishes the Credentialled diabetes educator adjust carbohydrate/insulin ratios for self-management of insulin therapy.	☐ Yes ☐ No
The referring doctor wishes the Credentialled diabetes educator commence the patient on a bolus advice calculator if the patient agrees or requests.	☐ Yes ☐ No

Prescribers Signature: ____________________ Date: ____________________