Referral Form

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
968b Albany Hwy, East Vic. Park WA 6101
P: (08) 6110 0570 | F: (08) 9355 571
E: admin@perthdiabetescare.com.au

Clinic preferred for appointment:

☐ East Victoria Park ☐ Telethon Type 1 Diabetes Family Centre (Type 1 Diabetes only, 16-30 yo)
☐ High Wycombe ☐ Other _____

Referring Doctor Details (Stamp)

Name: _____
Address: _____
_____
Phone No: _____ Fax No: _____
Provider No: _____
Preferred correspondence for letters:
☐ Mail ☐ Email ☐ Other _____

Patient Details

Name: _____
Address: _____
DOB: _____ Gender: M / F Ph: _____ Mob: _____
Medicare #: _____ ( ) Exp: _____
Concession card holder: ☐ Yes ☐ No Registered with NDSS: ☐ Yes ☐ No
Aboriginal or Torres Strait Islander: ☐ Yes ☐ No Suitable for Group Education: ☐ Yes ☐ No
Interpreter Required: ☐ No ☐ Yes, if yes which language: _____
Current Endocrinologist (if applicable): _____

Medical Conditions

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ IGT ☐ IFG ☐ Gestational Diabetes ☐ Type 1 Diabetes with pregnancy
Other: _____ Date of Diagnosis (if known): _____

Reason for referral

☐ Newly Diagnosed
☐ Education Review
☐ Group Diabetes Education
☐ 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 loss / Diet Review
☐ Assessment for Group Education
☐ Group Exercise Classes
☐ Spirometry Testing
☐ Musculoskeletal Rehabilitation
☐ Cardiovascular Rehabilitation
☐ Other: _____

Referral for:

☐ Credentialled Diabetes Educator ☐ Accredited Practising Dietitian ☐ Counsellor ☐ Podiatrist
☐ Exercise Physiologist (Individual appt) ☐ Exercise Physiologist (Group Session) ☐ Clinical Psychologist

Please attach the following

Recent relevant results: ☐ GP Management Plan (MBS Item 721) ☐ Team Care Arrangement (MBS Item 723) (or considering pregnancy)
☐ Medicare Referral Form for Individual Allied Health Services (MBS Item 10950 - 10970)
☐ Referral form for Group Allied Health Services under Medicare for patients with Type 2 Diabetes *(if applicable for exercise classes)* (MBS Item 81100, 81110, 81120, 81105, 81115, 81125)

GP & Patient Consent

My GP 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

Is it safe for your patient to exercise at a moderate intensity: ☐ Yes ☐ No

Are the any contraindications or precautions for your patient participating in group exercise:

☐ No ☐ Yes, Please specify: _____

Referrers signature: _____ Patient signature: _____ Date: _____

Insulin Stabilisation Order

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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: _____