Diabetes Tasmania Statewide Clinical Services Referral Form

Phone: 6215 9000 I Fax: 6215 9099 I HealthLink EDI: diabetas

Referral date: _____

Referrer details

Doctor name: _____ **Provider number:** _____

Practice name: _____ **Phone:** _____

Practice address: _____ **Fax:** _____

_____

Patient details Consent for contact

Name: _____ **Email:** _____

Date of birth: _____ **Ethnicity:** _____

Gender: _____ **ATSI:** _____

Address: _____ **Language spoken:** _____

_____ **Medicare number:** _____

Home phone: _____ **DVA number:** _____

Mobile: _____

Referral discussed with patient: Yes No **Interpreter required:** _____

Preferred contact (circle one): Mobile Home **Diabetes Diagnosis:** _____

Ok to leave message (circle one): Yes No **Years diagnosed**: _____

How we manage appointments:

A Diabetes Tasmania health professional will discuss this referral with the patient prior to booking an appointment. To manage our services effectively appointments are triaged based on pathology, treatment and other information provided in this referral. Referral cannot be progressed without this information.

About our services:

Individual appointments are available with a diabetes educator, dietitian, nurse practitioner, and social worker as needed, for adults with:
- type 2 diabetes or at high risk of diabetes
- type 1 diabetes diagnosed over 12 months and not using an insulin pump.

The COACH Program: six month telephone based program focused on achieving risk factor targets.
DESMOND group education: a one day self-management group program covering the basics of diabetes, monitoring, complications and goal setting.

SMART programs: a series of 3 hour topic specific diabetes group programs – ShopSmart, CarbSmart, MedSmart and FootSmart.

Describe current needs or goals of care:

_____

_____

_____

_____

_____

_____

Injectable medication commencement:

GLP1 type:_____

Insulin Type: _____ Dose: _____ Frequency: _____

Insulin Type: _____ Dose: _____ Frequency: _____

Allergies and intolerances: _____

_____

Current and past medical history: _____

_____

_____

Current medications: _____

_____

_____

Smoking status: _____

Please attach relevant pathology: ***Eg. OGTT HbA1c Total Chol HDL LDL Triglycerides Vitamin D TFT FBC Micro alb.***