

Diabetes Education Referral Form

Referral Date: ____ / ____ / ____

Patient Details: Date of birth: ____ / ____ / ____

Name: _____ Contact number: _____

Postal Address: _____

Suburb/Community: _____ State: _____ Postcode: _____

Diabetes type:

- Type 1 Type 2 Gestational Impaired Glucose Tolerance
 Other (please specify): _____

Current Diabetes Rx:

Random BGL: _____

O.G.T.T

Fasting: _____
 1 Hour: _____
 2 Hour: _____

Diabetes Complications Identified:

- Retinopathy
 Neuropathy
 Vascular Disease (Cardiac, Peripheral)
 Renal Disease

Other Health Problems:

Other Medications:

Recent Investigations:

Fasting Chol: _____ Trig: _____ LDL Chol: _____ HDL Chol: _____
 HbA1C: _____ BP: _____ ACR: _____

Any Special Requests:

Referring Doctor's Name: _____

Medical Centre: _____ Provider #: _____

Signature: _____

Please send referral via fax: **08 8927 8515** or via HealthLink EDI: **healthnt**