

**Primary Care Referral to Diabetes Specialist Nurse / Dietitian**

**Patient Details:**

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| --- | --- | --- | --- | --- | --- |
| Hospital no. |  | NHS no. |  | | |
| Surname |  | Forenames |  | | |
| Previous surname |  | Title |  | Gender |  |
| Date of birth |  |  |  | | |
| Address  Post Code |  | Home tel. no. |  | | |
|  |  | Work tel. no. |  | | |
|  |  | Mobile no. |  | | |

**Referral Details:**

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| --- | --- | --- | --- | --- | --- |
| Referring clinician |  | Urgent |  | | |
| GP Practice/ Department |  | New referral? |  | Re-referral? |  |
| Date of referral |  | Date last seen |  | | |
| Date of consultation |  | Dates not available |  | | |

**Communication needs**

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| Newly diagnosed |  |  | Date of diagnosis: | |  | |
| **Established Diabetes** |  |  | Date of diagnosis: | |  | |
| **Current follow-up** | GP |  | Hospital |  | Shared |  |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Type of Diabetes | | Type 1 |  | Type 2 |  | Type 2 on insulin |  |
| Diabetes treatment including dose(s) and frequency | | | | Other relevant medication | | | |
| Diet only |  | | |
| Insulin |  | | |
| Oral medication |  | | |
| Incretin mimetic (injectable therapy) |  | | |

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| --- | --- | --- | --- |
| Relevant results | | Home self monitoring Patients being referred for consideration of insulin / other injectables must be blood glucose monitoring at varied times prior to 1st appointment and bring a record with them | |
| Fasting blood glucose |  | Blood glucose |  |
| Random blood glucose |  | Urine testing |  |
| HbA1c |  | Blood glucose meter (if known) |  |
| Cholesterol | HDL LDL |  | |
| Blood pressure |  | Add ACR (albumin creatinine ratio) |  |
| Weight | Height | Body Mass Index |  |

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| --- | --- | --- |
| Reason for Referral | | Other relevant information eg sight, language, hearing or learning difficulties, social issues, co-existing medical problems, current diabetes issues, etc. |
| Newly diagnosed requiring 1:1 advice (must meet WHO criteria 2011) |  |  |
| Poor control on maximum oral therapy for assessment |  |
| Consideration of insulin / other injectable therapy |  |
| Review / change current insulin regime |  |
| **Specialist dietry advice (please be specific)** | |
| **Patient on basal bolus needing help with carbohydrate awareness / dose titration** | |
| Note: For referrals to DESMOND type 2 diabetes education programme, please use separate referral form: *DESMOND group education sessions for newly diagnosed type 2 patients*. | | |

Any questions? Please contact the Diabetes Specialist Nurses on tel. no. 01722 425176

# Please fax referral to the Diabetes Nursing Service: Tel.01722 425143, or post to the: Diabetes Education Centre, Salisbury District Hospital, Salisbury, Wiltshire, SP2 8BJ.