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| --- | --- |
| Date of referral: |  |
| Patient Name: |  |
| Patient Contact Number: |  |
| Patient Address:  |  |
| Interpreter Needs/Primary Language: |  |
| Service Requested (Please select option below): *Note: We are a Nurse Led Clinic. To refer to an Endocrinologist, please contact the Outpatients Department.* |
| Diabetes Nurse Educator |
| Diabetes Dietitian Dietitian will see Patients with Type 1 Diabetes, Patients on Insulin & Patients who have GDM |
| Type of Diabetes (Please select option below): |
| Type 1 Diabetes  | Type 2 Diabetes  | Gestational Diabetes  | Other (Please specify below) |
| Reason for Referral (please select option below) |
| Newly Diagnosed  | Oral Hypoglycaemic Agent  | Insulin Start  | Poor Control  |
| BGL Monitoring  | Other (Please specify below; note we do have a Referral criteria)  |
| CLIINICAL INFORMATION:  |  |
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|  |
| CURRENT DIABETES MANAGEMENT: |  |
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|  |
| Name of Referring Doctor: |  | Provider Number: |  |
| Address of Practice: |  |
| Phone: |  | Fax: |  |
| Signature: |  |
| Please fax this form to us as soon as possible. We will contact the patient to make an appointment. If we cannot accommodate the referral – we will contact you. Please call if you have any questions. St George Diabetes Education CentrePh: (02) 9113 2774 (Between the hours of 8:30am and 3:00pm Monday to Friday)Fax: (02) 9113 2690Email: SESLHD-StGeorge-DiabetesEdu@health.nsw.gov.au  |