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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: | | |  | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
| 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 Centre  Ph: (02) 9113 2774 (Between the hours of 8:30am and 3:00pm Monday to Friday)  Fax: (02) 9113 2690  Email: [SESLHD-StGeorge-DiabetesEdu@health.nsw.gov.au](mailto:SESLHD-StGeorge-DiabetesEdu@health.nsw.gov.au) | | | | | | | | | | | |