|  |  |  |
| --- | --- | --- |
| DOB |    | PID Number |
| Gender |   |   |
| Title |   | Surname |   |
| Given Names |   |
| Address |   |
|  | *(Type or affix sticker)* |

|  |
| --- |
| **REQUEST FOR** |
| *[ ] [ ]* ***Diabetes Education clinic*** *(available in Peel, Midwest and Busselton regions)* or*[ ] [ ]* ***Health Navigator*** *(self-management support for diabetes, heart conditions and long-term lung conditions - available for Wheatbelt, Great Southern and South-West regions)*or*[ ] [ ]* ***Continence Clinic*** *(available in Midwest when person is not eligible for CMAS)*  |
| **CLIENT DETAILS** |
| Full Name:       | DOB:       |
| Address:       |
| Email:       | Telephone:       |
| Medicare Card (include number/reference/expiry) : |
| Health Care card (if applicable):       |
| Next of Kin (NOK)/Carer Name:       | NOK/Carer Telephone:       |
| Aboriginal [ ] [ ]  Torres Strait Islander [ ] [ ]  Both [ ] [ ]  Neither [ ] [ ]  |
| Does the client have a Home Care Package? Yes [ ]  No [ ] HCP Level: [ ] [ ]  Level 1 [ ] [ ]  Level 2 [ ] [ ]  Level 3 [ ] [ ]  Level 4 |
| Does the client have NDIS support? Yes [ ]  No [ ]  |
| Are there any concerns with the client communicating via telephone Yes [ ]  No [ ]  |
| Has client consented to this referral? Yes [ ]  No [ ]  |
| **REFERRAL DETAILS** |
| Diagnosis:       |
| Reason for referral:       |
| Relevant Medical History:       |
| Relevant Social History:       |
| Other factors: *(such as hearing impairment, cognition, risk factors)*      |

|  |
| --- |
| Clinical supporting documentation enclosed:[ ]  *Yes* [ ]  *N/A* Discharge/Health Summary[ ]  *Yes* [ ]  *N/A* Pathology results (HbA1c, FBGL, OGTT, lipids) [ ]  *Yes* [ ]  *N/A* GP Management Plan[ ]  *Yes* [ ]  *N/A* Specialist reports – Urology, Urogynaecology or Gynaecology, Endocrinology |
| **CURRENT MEDICATIONS (including allergies)**  |
|       |
| **REFERRER DETAILS** |
| Referrer Name:       | Telephone:       |
| Referring Organisation:       | Fax:       |
| Referrer Provider No. (if applicable):       | Date completed:       |
| Referrer Email:       |
| Client’s GP (if referrer is not GP):  |

**INSULIN THERAPY ORDER**

*Please only complete* w*hen requesting support with insulin therapy,* ***GP must complete this section***

|  |  |  |
| --- | --- | --- |
| **Type (s) of Insulin** | **Starting Dose** | **Time and Regimen** |
|       |       |       |
|       |       |       |
|       |       |       |
| **Target Blood Glucose Range:**       | Size of Incremental Adjustments:      |
| Fasting:       | Post Prandial:       |
| **Case Management for Client Commencing Insulin Therapy in the Ambulatory Setting:** Please tick the appropriate section otherwise referral is INVALID[ ]  *Referring doctor wishes Diabetes educator to adjust insulin doses until BG targets achieved* [ ]  *Referring doctor will adjust insulin doses.*  |
| Referring Doctor: |       | Work Phone: |       |
| Practice: |       | Mobile: |       |
| Address: |       | Email: |       |
| Postcode: |       |  |  |
| **Doctor’s Signature:** |  | Date: |       |

**Please complete and fax individual referral to 1300 601 788**

**or email** **SCReferrals@silverchain.org.au**