

Date _____

The Endocrinologist
Diabetes Telehealth Endocrinology Service
Diabetes WA
Level 3
322 Hay Street
Subiaco 6008

Dear Doctor

Thank you for seeing

Patient Name: _____

Contact Number: _____

Date of Birth: _____

Address: _____

Reason for Referral or any additional comments: -

Patient to be reviewed by a Diabetes Telehealth Diabetes Educator **YES / NO**

Kind regards (Insert medical practice stamp with GP provider number)