

Self-Referral Form

IMPORTANT NOTICE: The information contained in this document is confidential. If you receive this message in error, please notify us immediately and return the original message to Diabetes WA.

My Health Record: The Diabetes Telehealth Service accesses your My Health Record prior to and during your appointment. If you do not wish for this to happen, please contact us at least 1 business day before your appointment.

Please complete the following information to the best of your ability.
You can also be referred to the diabetes telehealth service by calling **1300 001 880**.

Your Personal Details		Date Referral Sent:	
Universal Medical Record Number (UMRN) if known:			
What hospital gave you this number?			
Title: <input type="checkbox"/> Mr <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Mrs		First Name:	
Middle Name(s):		Last Name:	
Previous/Maiden Name:		Preferred Name:	
Address:			Postcode:
Postal Address:			Postcode:
DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Email:	
Telephone:	Mobile:	Other:	
Medicare Number:	Reference No:	Expiry Date:	
Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No		Language Spoken:	
Aboriginal/Torres Strait Islander: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Next of Kin			
First Name(s):		Last Name:	
Relation:		Contact Number:	
Your GP Details			
GP's Name:			
Clinic Name:		Telephone No:	
Address:		Fax No:	
Your Diabetes Type (please check)			
<input type="checkbox"/> Type 1		<input type="checkbox"/> Type 2	
		<input type="checkbox"/> Type 2 Requiring Insulin	
Other (Gestational, Steroid Induced etc., please detail):			
Date of Diagnosis: (If unknown, state the number of months or years diagnosed months/years)			
Registered with Health Navigator: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure			
Registered with National Diabetes Service Scheme (NDSS): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure			
If yes, please provide NDSS registration number:			
Reason For Contacting Service:			
FEEDBACK: (OFFICE ONLY)	DATE:	REFERRAL RECEIVED BY:	SIGNATURE/DESIGNATION:

Return the completed form via:

Fax : (08) 9221 1183 | Email : telehealth@diabeteswa.com.au

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