Diabetes WA Clinic Diabetes Education Referral Form

MEDICARE REBATES: If patient is eligible for Medicare Rebates under a GPMP and TCA, please attach to this referral.

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 WA Clinic accesses My Health Record prior to and during appointments. If the client does not consent, please contact us at least 1 business day before the appointment.

Please tick	YES if this is o	an URGEN	T referral	: Yes	No (Urgent refe	rrals will attempt to	o be seen within 7 days)
Client Deta	ills (please c	omplete /	ALL section	ons)			
Title:	Surname:				Given names:		
Address:							Postcode:
DOB:		Gend	er:		Aboriginal/TSI:	Yes No	
Telephone: Mob:					Email:		
Medicare Number:					Reference No: Expiry Date:		
Interpreter Required: Yes No					Language:		
Next of Kin	Details						
Name					Relationship		
Telephone					Email		
Referral Source					Date Referral Sent:		
Title:	Surname:				Given Names:		
Agency Nam	ne:		Address:				Postcode:
Telephone:		Email:				Facsim	nile:
	actitioner De	tails (if dif	ferent fro	m above)			
Title: Dr	Surname:				Given Names:		
Practice Nam	ne:		Address:				Postcode:
Telephone: Email:						Facsim	nile:
	pe (please che						
Type 1	Type 2	Type 2 insu	Jlin	Other:		Date of Diagnos	sis:
Pre-diabe				NDSS Regis		NDSS No:	
Includes insulin resistance, at risk of diabetes)				Yes	No		
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Medication	ns: Yes	No (List wi	th dose & fr	equency) Ins	ulin: Yes	No (List dose &	frequency)
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Return completed form via:

Telephone: (08) 9436 6290 | Email: Clinic@diabeteswa.com.au | Fax: (08) 9221 1183

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