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 an URGENT referral: ☐ **Yes** ☐ **No** (Urgent referrals will attempt to be seen within 7 days)			
Client Details (please complete ALL sections)			
Title:	Surname:	Given names:	
Address:			Postcode:
DOB:	Gender:	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 Name:	Address:		Postcode:
Telephone:	Email:		Facsimile:
General Practitioner Details (if different from above)			
Title: Dr	Surname:	Given Names:	
Practice Name:	Address:		Postcode:
Telephone:	Email:		Facsimile:
Diabetes Type (please check)			
☐ Type 1 ☐ Type 2 ☐ Type 2 insulin		Other:	Date of Diagnosis:
☐ Pre-diabetes Includes insulin resistance, at risk of diabetes)		NDSS Registration: ☐ Yes ☐ No	NDSS No:
Medications: ☐ **Yes** ☐ **No** (List with dose & frequency) **Insulin:** ☐ **Yes** ☐ **No** (List dose & frequency)			
Pathology: Copies Attached: ☐ **Yes** ☐ **No** (Please indicate results and date)			
Weight (kg):	HbA1c (mmol/mol or %):	LDL-C (mmol/L):	
Height (cm):	Total Chol (mmol/L):	Micro albuminuria (mg/L):	
BMI:	Triglycerides (mmol/L):	ACR (mg/mmol/L):	
BP (mmHg):	HDL-C (mmol/L):	eGFR (ml/min/1.73m$_2$):	
Medical Conditions: **Yes** **No** (Please check boxes below)			
☐ MI	☐ CHF	☐ Angina	☐ Hypertension
☐ Hyperlipidaemia	☐ CVA	☐ PVD	☐ Nephropathy
☐ Dialysis	☐ Neuropathy	☐ Retinopathy	☐ Cataracts
☐ Glaucoma	☐ COPD	☐ Asthma	☐ Hypo/Hyperthyroidism
☐ Immune Condition	☐ Dementia	☐ Cancer	☐ Mental Health Condition
Other (please list)			
Surgical History: ☐ Yes ☐ No	☐ CABG ☐ Stent (heart) ☐ Stent (leg) ☐ Other:		
Allergies/Alerts: ☐ Yes ☐ No	Allergy details:		
Reason for Referral:			

Return completed form via:
Telephone: **(08) 9436 6290** | Email: **Clinic@diabeteswa.com.au** | Fax: **(08) 9221 1183**
Level 3, 322 Hay Street, SUBIACO WA 6008 | PO Box 1699, SUBIACO WA 6904

2022-114