Diabetes WA Referral Form

diabetesWA by your side

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.

MEDICARE REBATE (METRO ONLY): If patient is eligible for Medicare Rebates under GPCCMP, please attach to this referral.

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)			
URN:	Registered with Health Navigator: ☐ Yes ☐ No		
UMRN:		Site:	
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:	
Referred By:		Date Referral Sent:	
Title:	Surname:	Given Names:	
Agency Name:	Address:		Postcode:
Telephone:	Email:		Facsimile:
Future correspondence to be sent to:			
Name:	Email:		Facsimile:
General Practitioner Details		GP Aware of Referral: ☐ Yes ☐ No	
Title: Dr	Surname:	Given Names:	
Practice Name:	Address:		Postcode:
Telephone:	Email:		Facsimile:
Diabetes Type (Please check)			
☐ Type 1 ☐ Type 2 ☐ Gestational	Other:	Date of Diagnosis:	
NDSS Registration: ☐ Yes ☐ No	NDSS No:	Urgent Referral: ☐ Yes ☐ No	
Reason for Referral:			
Medications: ☐ Yes ☐ No (If yes, list with dosage, frequency & route)			
Referred by Diabetes Connect consult: ☐ Yes ☐ No			
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:		

For more information, please contact:
Healthlink: DWATEL3H | Telephone referrals: 1300 001 880 | Fax referrals: (08) 9221 1183
| Country WA Email:telehealth@diabeteswa.com.au | Perth Metro Email: clinic@diabeteswa.com.au |
Level 3/322 Hay Street Subiaco, WA 6008

The Diabetes Telehealth Services is delivered by Diabetes WA in partnership with WA Country Health Services and WA Primary Health Alliance