DIABETES CLINIC REFERRAL FORM

Client Details		
Name:	Home/Work Phone:	
Address:	Mobile Phone:	
DoB (over 18yrs only):	Email:	
Identifies as: ☐ Aboriginal ☐ TSI ☐ CALD		
Next of Kin Name:	Relationship:	Contact #:
Medicare Care Number:	Ref #:	Exp:

GP Details – referrals from GP/RAN/NP - GPMP accepted	
Name:	Phone:
Practice:	Email:
Practice Address	Fax:

Reason For Referral

Insulin Therapy Order
(please only complete when requesting support with insulin therapy **GP must complete this section**)

Type(s) of Insulin	**Starting Dose**	**Time and Regime**

Target Blood Glucose Range		
Size of Incremental Adjustments:	Fasting:	Post Prandial:

Case Management for Client Commencing Insulin Therapy in Ambulatory Setting:
(please check the appropriate section otherwise referral is invalid)

☐ Referring GP wishes Diabetes Educator to adjust insulin doses until BG targets are met.

☐ Referring GP will adjust insulin doses.

GP Signature:	Date:

Consent
I have discussed this referral and the information above with the client and consent has been provided for a referral to this program.

Client Name:		Client Signature:		Date	

Referrals to phhreferrals@oseca.com.au

PLEASE PROVIDE YOUR CLIENT A COPY OF THIS REFERRAL