



Health Professional 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. Please note each referral should be faxed individually.

Client Details (please complete ALL sections)			
URN:	Registered with Health Navigator: <input type="checkbox"/> Yes <input type="checkbox"/> No		
UMRN:	Site:		
Title:	Surname:	Given names:	
Address:			Postcode:
DOB:	Gender:	Aboriginal/TSI: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Telephone:	Mob:	Email:	
Medicare Number:	Reference No:	Expiry Date:	
Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No		Language:	
Referral Source		Date Referral Sent:	
Title:	Surname:	Given Names:	
Agency Name:		Address:	Postcode:
Telephone:	Email:	Facsimile:	
General Practitioner Details		GP Aware of Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Title: Dr	Surname:	Given Names:	
Practice Name:		Address:	Postcode:
Telephone:	Email:	Facsimile:	
Diabetes Type (please check)			
<input type="checkbox"/> Type 1	<input type="checkbox"/> Type 2	<input type="checkbox"/> Type 2 insulin	Other:
Date of Diagnosis:			
NDSS Registration: <input type="checkbox"/> Yes <input type="checkbox"/> No	NDSS No:	Urgent Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reason for Referral:			
Medications: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, list with dosage, frequency & route)			
Pathology: Copies Attached <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No (Please check boxes below)			
<input type="checkbox"/> MI	<input type="checkbox"/> CHF	<input type="checkbox"/> Angina	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Hyperlipidaemia	<input type="checkbox"/> CVA	<input type="checkbox"/> PVD	<input type="checkbox"/> Nephropathy
<input type="checkbox"/> Dialysis	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Retinopathy	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> COPD	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hypo/Hyperthyroidism
<input type="checkbox"/> Immune Condition	<input type="checkbox"/> Dementia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Mental Health Condition
<input type="checkbox"/> Other (please list)			
Surgical History: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> CABG <input type="checkbox"/> Stent (heart) <input type="checkbox"/> Stent (leg) <input type="checkbox"/> Other:	
Allergies/Alerts: <input type="checkbox"/> Yes <input type="checkbox"/> No		Allergy details:	
FEEDBACK: (OFFICE ONLY)	DATE:	RECEIVED BY:	SIGN/DESIGNATION

For more information, please contact:

Telephone referrals: **1300 001 880** | Fax referrals: **(08) 9221 1183** | Email: **telehealth@diabeteswa.com.au**