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| --- | --- | --- | --- | --- | --- |
| **WILTSHIRE DIABETES OUTPATIENTS REFERRAL FORM**  BY SENDING THIS REFERRAL FORM, YOU ARE CONFIRMING THAT THE PATIENT HAS CONSENTED TO CONTACT AND SUPPORT BY THE SPECIALIST SERVICES SUPPORTING PATIENTS WITH DIABETES IN WILTSHIRE | | | | | |
|  | | | | | |
| REFERRAL DATE | <TODAY'S DATE> | | | | |
| DATE OF BIRTH | <DATE OF BIRTH> | NHS NO. | | <NHS NUMBER> | |
| SURNAME | <PATIENT NAME> | FORENAMES | | <PATIENT NAME> | |
| PREVIOUS SURNAME | <PATIENT NAME> | TITLE | <PATIENT NAME> | SEX | <GENDER> |
| ADDRESS | <PATIENT ADDRESS> | DAYTIME TEL NO. | | <PATIENT CONTACT DETAILS> | |
| MOBILE NUMBER | | <PATIENT CONTACT DETAILS> | |
| INTERPRETER NEEDED  LANGUAGE | | YES  NO  <MAIN SPOKEN LANGUAGE> | |
| REFERRING CLINICIAN | <SENDER NAME> | GP PRACTICE / REFERRING ORGANISATION OR DEPARTMENT | | <SENDER DETAILS>  <SENDER ADDRESS>  <SENDER DETAILS> | |

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| **REFERRAL DETAILS** | | | |
| **REASON DIABETES SPECIALIST SUPPORT REQUESTED?** | | | |
| TYPE OF DIABETES | TYPE 1  TYPE 2  OTHER  (PLEASE INCLUDE DETAILS BELOW) | DATE OF DIAGNOSIS |  |
| HOME VISIT REQUESTED?  (SERVICE WILL ASSESS IF FULFIL CRITERIA) | YES  NO  (PLEASE INCLUDE REASON BELOW) | ALREADY UNDER SPECIALIST CARE? | YES  NO  SPECIALIST NAME + ORGANISATION |
| ANY CONDITION / ILLNESS THAT MAY AFFECT MENTAL CAPACITY TO CONSENT TO ASSESSMENT / TREATMENT? | YES  NO  (PLEASE INCLUDE DETAILS BELOW) | ANY RELEVANT SAFEGUARDING INFORMATION? | YES  NO  (PLEASE INCLUDE DETAILS BELOW) |
| HAS THE PATIENT AGREED TO RECEIVE **TEXT MESSAGES** ABOUT THEIR APPOINTMENTS TO THE MOBILE PHONE NUMBER LISTED ABOVE?  YES  NO | | | |
| **OTHER RELEVANT INFORMATION?** | | | |

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| **TEST RESULTS** | **CURRENT**  **(WITHIN LAST TWO MONTHS)** | |
|  | **RESULT** | **DATE** |
| HBA1C | <NUMERICS> | |
| CHOLESTEROL | <NUMERICS> | |
| CREATININE | <NUMERICS> | |
| EGFR | <NUMERICS> | |
| TOTAL CHOLESTEROL | <NUMERICS> | |
| TRIGLYCERIDES | <NUMERICS> | |
| NON-HDL | <NUMERICS> | |
| HDL | <NUMERICS>, | |
| ALBUMIN/CREATININE RATIO | <NUMERICS> <NUMERICS> | |

|  |  |  |
| --- | --- | --- |
|  | **CURRENT**  **(WITHIN LAST 12 MONTHS)** | |
| **RESULT** | **DATE** |
| WEIGHT (KG) | <NUMERICS> | |
| HEIGHT | <NUMERICS> | |
| BMI | <NUMERICS> | |
| BLOOD PRESSURE | <LATEST BP>, <NUMERICS> | |
| FOOT RISK |  | |
| RETINAL CHECK |  | |
| SMOKING | <DIAGNOSES>, <NUMERICS> | |
| ALCOHOL | <DIAGNOSES>, <NUMERICS> | |

|  |  |  |
| --- | --- | --- |
| **MEDICATION** | ACUTES | <MEDICATION> |
| REPEATS | <REPEAT TEMPLATES> |
| **ALLERGIES** | <ALLERGIES & SENSITIVITIES> | |
| **PAST MEDICAL HISTORY** | <PROBLEMS>  <SUMMARY> | |
| **PLEASE ENSURE THAT ALL FIELDS ARE COMPLETED CORRECTLY.**  **INCOMPLETE OR ILLEGIBLE FORMS WILL BE RETURNED TO THE REFERRER** | | | | |

FORM SHOULD BE SENT VIA E-REFERRAL FROM SYSTMONE OR BY SECURE EMAIL TO [WHC.DIABETESREFERRALS@NHS.NET](mailto:WHC.DIABETESREFERRALS@NHS.NET)