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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> |

|  |  |
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|  | **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> |

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| **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