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| **WILTSHIRE DIABETES STRUCTURED EDUCATION 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> | | | | |
| NHS NO. | <NHS NUMBER> | DATE OF BIRTH | | <DATE OF BIRTH> | |
| 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> | |
| REFERRING CLINICIAN | <SENDER NAME> | GP PRACTICE / REFERRING ORGANISATION OR DEPARTMENT | | <SENDER DETAILS>  <SENDER ADDRESS>  <SENDER DETAILS> | |
| ETHNICITY | <ETHNICITY> | INTERPRETER NEEDED  LANGUAGE: | | YES  NO  <MAIN SPOKEN LANGUAGE> | |
| **ANY RELEVANT SAFEGUARDING INFORMATION?**  YES  NO  (IF YES, PLEASE INCLUDE RELEVANT DETAILS) | | | | | |

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| **REFERRAL DETAILS** | | | | | | | |
| **PLEASE CONTACT THE ABOVE PATIENT TO DISCUSS DIABETES STRUCTURED EDUCATION** | | | | | | | |
| TYPE OF DIABETES | | | TYPE 1  TYPE 2 | DATE OF DIAGNOSIS |  | | |
| **PREFERENCES**  DIGITAL/ONLINE EDUCATION  FACE TO FACE EDUCATION PROVIDED IN GROUP FORMAT  PATIENT REQUIRES ONE TO ONE EDUCATION (**PROVIDE REASON BELOW**) | | | | | | YES  YES  YES | |
| HAS THE PATIENT AGREED TO RECEIVE **TEXT MESSAGES** ABOUT THEIR APPOINTMENTS TO THE MOBILE PHONE NUMBER LISTED ABOVE?  YES  NO  WHERE **DIGITAL/ONLINE EDUCATION** **IS DEEMED APPROPRIATE**, THE PATIENT HAS AGREED TO SHARE THE INFORMATION ON THIS REFERRAL FORM WITH THE DIGITAL EDUCATION PROVIDER?  YES  NO | | | | | | | |
| **OTHER RELEVANT INFORMATION?**    <EVENT DETAILS> | | | | | |
| **MEDICAL PROBLEMS:**    <PROBLEMS>  <SUMMARY> | | | | | |
| **MEDICATION:** | | | | | |
| ACUTES | <MEDICATION> | | | | |
| REPEATS | <REPEAT TEMPLATES> | | | | |
| **ALLERGIES:**  <ALLERGIES & SENSITIVITIES> | | | | | |

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| **TEST RESULTS** | **CURRENT**  **(WITHIN LAST 12 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> | |
| SMOKING | <DIAGNOSES>, <NUMERICS> | |
| ALCOHOL | <DIAGNOSES>, <NUMERICS> | |

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| **PLEASE ENSURE THAT ALL FIELDS ARE COMPLETED CORRECTLY.**  **INCOMPLETE OR ILLEGIBLE FORMS WILL BE RETURNED TO THE REFERRER** |

FORM SHOULD BE SENT TO [**WHC.DIABETESWELLBEING@NHS.NET**](mailto:WHC.DIABETESWELLBEING@NHS.NET)