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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of Service referring to: DIABETES**  **By making this referral the patient agrees to receive text and email messages about their referral, appointments and management to the mobile phone number and email address listed below.**  **REFERRAL CRITERIA**  **URGENT (same day) Referral by telephone only 01249 456483**   * New onset Type 1 diabetes   **PRIORITY**   * Frequent hypoglycaemia or impaired hypoglycaemic awareness   **NON-URGENT**   * Type 1 diabetes with sub-optimal or unstable diabetes management * Type 1 diabetes requiring technology * Type 2 diabetes with sub-optimal diabetes management on triple therapy where practices are unable to support insulin initiation * Type 2 diabetes on insulin where practices are unable to support insulin adjustment * Type 1 diabetes distress (psychological) * Learning disability where carer education & support required | | | | | | | | |
| **GENERAL REFERRAL INFORMATION** | | | | | | | | |
| REFERRAL DATE | | <TODAY'S DATE> | | | | | | |
| DATE OF BIRTH | | <DATE OF BIRTH> | NHS NO. | | | <NHS NUMBER> | | |
| FAMILY NAME | | <PATIENT NAME> | GIVEN NAME | | | <PATIENT NAME> | | |
| PREVIOUS FAMILY NAME | | <PATIENT NAME> | TITLE | | <PATIENT NAME> | SEX | | <GENDER> |
| ADDRESS | | <PATIENT ADDRESS> | DAYTIME TEL NO. | | | <PATIENT CONTACT DETAILS> | | |
| MOBILE NUMBER | | | <PATIENT CONTACT DETAILS> | | |
| EMAIL ADDRESS | | | <PATIENT CONTACT DETAILS> | | |
| INTERPRETER NEEDED  LANGUAGE | | | YES  NO  <MAIN LANGUAGE> | | |
| ANY CONDITION / ILLNESS THAT MAY AFFECT MENTAL CAPACITY TO CONSENT TO ASSESSMENT / TREATMENT? | | YES  NO  (PLEASE INCLUDE DETAILS BELOW) | IS THE PATIENT AWARE OF THIS REFERRAL? | | | YES  NO | | |
| IS THE PATIENT A CARER? | | | YES  NO | | |
| ANY RELEVANT SAFEGUARDING INFORMATION? | | YES  NO  (PLEASE INCLUDE DETAILS BELOW) | FOR 14-25 YEAR OLDS, IS THIS REFERRAL PART OF TRANSITION PLANNING TO ADULT SERVICES?  YES  NO | | |  | | |
| REFERRING CLINICIAN | | <SENDER NAME> | GP PRACTICE / REFERRING ORGANISATION OR DEPARTMENT | | | <SENDER DETAILS>  <SENDER ADDRESS>  <SENDER DETAILS> | | |
| **REASON DIABETES SPECIALIST SUPPORT REQUESTED?**   * **Please be specific and give as much information as possible e.g. past and current treatment plans.** * **Please ensure the patient has up-to-date blood tests (within 8 weeks)** | | | | | | | | | | |
| TYPE OF DIABETES | | TYPE 1  TYPE 2  OTHER  (PLEASE INCLUDE DETAILS BELOW) | | | DATE OF DIAGNOSIS | | | 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) | | |

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