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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
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| **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)**
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| 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 SERVICE NHS.NET EMAIL