**COMMUNITY DIABETES TEAM - REFERRAL FORM**

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| **Section 1 – Patient Details** |  |
| **Surname:** …………………………………**Forename(s):** …………………………………**Date of Birth:** \_ \_ / \_ \_ / \_ \_ \_ \_**NHS No** ­\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ | **Address:.** ………………………………………………….……………………………………………………………….……………………………………………………………….**Home Tel:** ………………………………………………….**Mobile**: …………………………………………………….. |
| **Interpreter required:** Yes □ No □ | **Language required:** |
|  |  |
| **Section 2 – Governance of referral** |  |
| **CONSENT**: The importance of sharing information with all professional staff involved in the patients care has been explained to the patient or carer.  | Verbal Consent Given □ Unable to Give Consent □ |

**Please ensure that you have completed the initial governance/screening (Section 2) before continuing**

**For the referral to be accepted please attach relevant past medical history and current medications**

**Incomplete forms will be returned**

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| If the HbA1c has risen significantly (above 20mmol) in the last 12month have other investigations been carried out? | **Yes – details** | **No**  |
| If patient is suitable for a GLP-1 this can now be initiated within primary care (with the exception of Ozempic & Rybelus).Has this been considered for those with Type 2 diabetes with a higher BMI? (in accordance with NICE guidelines) | **Yes – details** | **No - details** |
| Has an annual review (Key Care Processes) been performed in the past 12month? | **Yes** | **No** |

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| **Section 3 – Referral Details** |  |
| **Referred By:** | **Date of Referral:** |
| **Type of Diabetes** : (Tick as appropriate) **Date of Diagnosis**: \_ \_ / \_ \_/ \_ \_ \_ \_□ Type 1 diabetes □ Type 2 oral therapy□ Type 2 Injectable therapy □ Other (pancreatitis, MODY) □ Unsure |
| **Reasons for Referral:** (Tick as appropriate) Please select Type 1 or Type 2 team

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| **Type 1 Diabetes Team** □ Newly diagnosed Type 1 diabetes □ Type 1 diabetes and emotional distress □ Technology support (Freestyle Libre) □ Type 1 HbA1c >65mmol □ Sudden rise in HbA1c >20mmol □ Frequent hypoglycaemia/unawareness  | **Type 2 Diabetes Team** □ HbA1c >65mmol on maximum oral therapy□ Complex needs – RRT, foot problems, end of  life support and enteral feeding regimens□ Steroid induced hyperglycaemia □ Complex dietary needs (that do not fit local  weight management programmes) □ Other – please add details below  |

Further Information/additional needs (use SBAR where possible)**Attach relevant past medical history and current medications** |
|  | **Result and date** |  | **Result and date** |
| HbA1c (mmol/mol) |  | Height (m) |  |
| Blood Pressure |  | Weight (kg) |  |
| eGFR |  | BMI (kg/m2) |  |
|  |  | Hip:Waist Ratio |  |
| **­­­­­****The shaded areas MUST be completed** |

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| Practice Stamp: / or Address of Hospital/ Community  | NHS email address: |

**Please email completed referral to:** medch.communitydiabetes@nhs.net

**Or via post to:** Community Diabetes Team, Unit 7, Ambley Green, Gillingham, Kent ME8 0NJ