**REFERRALS SHOULD BE MADE BY E-REFERRAL**

**Adult Diabetes Service Referral Form**

**Telephone 01226 435678**

**For use by GP Practices/Community Clinicians/External services**

**PLEASE ENSURE ALL FIELDS ARE COMPLETED, OTHERWISE THIS REFERRAL MAY NOT BE PROCESSED**

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| **Patient Details** | **GP** |
| **Name:**  **DOB:**  **NHS number:**  **Address:**  **Tel:**  **Mobile:**  **Patient Consent for information sharing?**  Yes  No | **Name of Referrer:**  **Date of Referral:**  **Registered GP:**  **Address:**  **Tel:**  **Practice Code:** |

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| **Ethnicity:**  **Main Language:**  **Interpreter Required:** Yes  No  **Does the patient have any communication requirements?**  Yes  No  **Is the patient registered disabled?**  Yes  No  **Safety**  **Do we need to be aware of any alerts?** | **Marital Status:**  **Religion:**  **Sexual Orientation:**  **Gender Reassignment:** Yes  No  **Has the patient consented to the referral?**  Yes  No  **Has the patient been under the Diabetes team before?**  Yes  No  **Date last seen:** |

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| **Date of Diagnosis:**  **Type of Diabetes**  **Type 1  Type 2  Other** |

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| **Urgency of Referral** |
| **Urgent**   (72 Hours) **Routine**   (6-8 weeks) **Crisis**  CRISIS = (same day intervention/within working hours) - please contact the Diabetes Team on 01226 240086 (this must be accompanied by an e-referral) |
| **Type 1 Diabetes**  Acutely unwell with type 1 Diabetes – with symptoms such as diarrhoea or vomiting - or any infection causing rise in diabetes control e.g. blood/urine ketones? Hyperglycaemia – **consider hospital admission**  **Suspected New onset Type 1**  **Yes ☐**  **No ☐**  **Is the patient symptomatic with the 4T’s (Thirst, Thinner, Toilet, Tired)?**  Glucose level?  Ketone level?  Family History?  **Contact Diabetes SPA Team urgently on 01226 435678** |

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| **Reason for referral** | |
| **Diabetes Specialist Nurse**  Maximum triple therapy    GLP-1 Start (**Hba1c >58 mmols/L)**    Insulin Initiation  Recurrent Hypos on Insulin    Persistent Hyperglycaemia    Terminal Illness and blood glucose level is unstable. ☐    Comments | **Specialist Care**  Pre-Conception  Antenatal  Adolescent and Young Adult Clinic  **(19-22 years old)**  Insulin Pump **(Type 1 only)**    Continuous glucose monitoring.  **(Must meet CGM NICE criteria for T1 and T2)** ☐ |
| **Other Services**    **Dietetics**  **Retinal Screening**  **For referral to the Acute Foot Team please refer to ESR (choose and book) and select option Diabetes acute foot.** | **Structured Education**  **Type 2 Education Group sessions**  **(XPERT)**  **Type 1 Education Group Sessions (DAFNE)** |

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| **Supporting information**  **Please ensure the following before referral for initiation of Insulin is made**  Patient is on maximum tolerated oral therapy and agrees to referral for Insulin.  [NG28 Visual summary on choosing medicines for type 2 diabetes in adults](https://www.nice.org.uk/guidance/ng28/resources/visual-summary-full-version-choosing-medicines-for-firstline-and-further-treatment-pdf-10956472093)  Please provide patient with a glucose meter and teach how to monitor.  Patient will need to provide 2 weeks of pre- meal and pre- bed blood glucose level results at their appointment. |
| **Please ensure you have completed the following before referral for titration of Insulin is made**  Examine injection sites for Lipohypertrophy **Yes No**  Ensure correct injection technique performed by patient **Yes No**  Ensure correct equipment used **Yes No** |

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| **BRIEF DESCRIPTION OF REFERRAL**  **Please include current medication/doses/previously discontinued medication or not tolerated.** |

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| **Referrals will not be accepted if bloods are over 4 weeks old and information below is incomplete** | | | | | |
| **Hba1c (within 1 Month):** | **Date of last test** | **Result** | **Serum Testosterone:** | **Date of last test** | **Result** |
| **Serum LDL cholesterol level**: | **Date of last test** | **Result** | **Retinal Screening** | **Date of last test** | **Result** |
| **Serum Total Cholesterol Level:** | **Date of last test** | **Result** | **BMI** | **Date of last test** | **Result** |
| **Serum creatinine level:** | **Date of last test** | **Result** | **Blood Pressure** | **Date of last test** | **Result** |
| **eGFR:** | **Date of last test** | **Result** | **Foot Examination** | **Date of last test** | **Result** |
| **LFT:** | **Date of last test** | **Result** | **Urine albumin/creatinine ratio:** | **Date of last test** | **Result** |

**Summary of Problems**

***Active***

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| **Date** | **Problem** | **Associated Text** | **Date Ended** |
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***Significant Past***

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| **Date** | **Problem** | **Associated Text** | **Date Ended** |
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| **MEDICATION AND ALLERGIES** |
| Current Medication ***Acute***   |  |  |  |  | | --- | --- | --- | --- | | **Drug** | **Dosage** | **Quantity** | **Last Issued On** | |  |  |  |  | |  |  |  |  | |  |  |  |  |   ***Repeat***   |  |  |  |  | | --- | --- | --- | --- | | **Drug** | **Dosage** | **Quantity** | **Last Issued On** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  |   **Allergies & Sensitivities**   |  |  |  | | --- | --- | --- | | **Date** | **Description** | **Associated Text** | |  |  |  | |  |  |  | |

*February 2025*