**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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| **MEDICATION AND ALLERGIES** |
| Current Medication***Acute***

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| **Drug** | **Dosage** | **Quantity** | **Last Issued On** |
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***Repeat***

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| **Drug** | **Dosage** | **Quantity** | **Last Issued On** |
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**Allergies & Sensitivities**

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| **Date** | **Description** | **Associated Text** |
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*February 2025*