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| **South East Essex Adult Diabetes Care Service Referral** | | | | | | | | |
| **NOTE TO THE REFERRER:** | | | | | | | | |
| * Please ensure consent for record sharing with the Adult Diabetes Care Service has been completed at the time of referral. * **Please ensure that all sections are completed – failure to complete in full will result in the referral being returned.** * Once completed, please attach to the patient’s record via SystmOne. If this is not possible, please send via email as an attachment to [diabetes.one@nhs.net](mailto:diabetes.one@nhs.net). * For any queries please call the **professional helpline on 01702 548094** or email [diabetes.one@nhs.net](mailto:diabetes.one@nhs.net) | | | | | | | | |
| **PATIENT DETAILS:** | | | | | | | | |
| Patient consents to referral and record sharing | | | | | | | Patient consents to receiving SMS messages | |
| Patient Name: | | | | | | | | |
| Date of Referral: | | | | Patient Address:  Contact Telephone Number: | | | | |
| NHS Number: | | | |
| Date of Birth: | | | |
| GP Name: | | | | Surgery Details: | | | | |
| **DIABETES TYPE & DATE OF DIAGNOSIS:** Please tick appropriate boxand add date of diagnosis | | | | | | | | |
| Type 1 | | Type 2 | | | Uncertain | | | **Date of Diagnosis:** |
| **Most recent HbA1c Result:** | | | | | | **Date of Result:**  *Must be up to date (within the last 4 weeks)* | | |
| **REASON FOR REFERRAL:** Please tick appropriate box below | | | | | | | | |
|  | All TYPE 1 DIABETES – Including those wanting support with technology | | | | | | | |
|  | Type 1 Structured Education Programme | | | | | | | |
|  | Type 2 Diabetes with Hba1c >58mmols on 3 or more agents which have been appropriately titrated | | | | | | | |
|  | Type 2 Diabetes with persistent Hypoglycaemia (4mmols or below) | | | | | | | |
|  | Type 2 Structured Education | | | | | | | |
|  | Admission Avoidance – i.e. Ketosis / Possible new onset Type 1 | | | | | | | |
|  | Diabetes Specialist Dietitian ( with Hba1c >58mmols)  Please state reason i.e. Weight reduction / Gastroparesis / Healthy Eating | | | | | | | |
|  | Referrals from District Nursing **only** - patient outside of pre-set blood glucose parameters: i.e.  Hypo ( 2 x episodes in 1 week ( b/g <4mmols )  Hyper ( 4 x episodes in 1 week ( b/g >15mmols ) | | | | | | | |
| **South East Essex Adult Diabetes Care Service Referral** | | | | | | | | |
| **ADDITIONAL INFORMATION:** Please provide details below | | | | | | | | |
|  | | | | | | | | |
| **BACKGROUND MEDICAL HISTORY:** Please provide details below | | | | | | | | |
|  | | | | | | | | |
| **CURRENT MEDICATION INCLUDING DOSE:** Please list all medication and dose | | | | | | | | |
|  | | | **Name of medication** | | | | | **Dose** |
| Medication 1: | | |  | | | | |  |
| Medication 2: | | |  | | | | |  |
| Medication 3: | | |  | | | | |  |
| Medication 4: | | |  | | | | |  |
| Medication 5: | | |  | | | | |  |
| Medication 6: | | |  | | | | |  |
| **PLEASE CHECK ALL SECTIONS HAVE BEEN COMPLETED IN FULL AND**  **ATTACH TO PATIENT RECORD OR RETURN BY EMAIL TO:** [diabetes.one@nhs.net](mailto:diabetes.one@nhs.net)  For any queries please call the professional helpline on 01702 548094 or email [diabetes.one@nhs.net](mailto:diabetes.one@nhs.net) | | | | | | | | |