|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| DOB |  | | | | PID Number | |
| Gender |  | | | |  | |
| Title |  | | | Surname |  | |
| Given Names | | |  | | | |
| Address | |  | | | | |
|  | | | | | | *(Type or affix sticker)* |

|  |  |
| --- | --- |
| **REQUEST FOR** | |
| ***Diabetes Education clinic*** *(available in Peel, Midwest and Busselton regions)*  or  ***Health Navigator*** *(self-management support for diabetes, heart conditions and long-term lung conditions - available for Wheatbelt, Great Southern and South-West regions)*  or  ***Continence Clinic*** *(available in Midwest when person is not eligible for CMAS)* | |
| **CLIENT DETAILS** | |
| Full Name: | DOB: |
| Address: | |
| Email: | Telephone: |
| Medicare Card (include number/reference/expiry) : | |
| Health Care card (if applicable): | |
| Next of Kin (NOK)/Carer Name: | NOK/Carer Telephone: |
| Aboriginal  Torres Strait Islander  Both  Neither | |
| Does the client have a Home Care Package? Yes  No  HCP Level:  Level 1  Level 2  Level 3  Level 4 | |
| Does the client have NDIS support? Yes  No | |
| Are there any concerns with the client communicating via telephone Yes  No | |
| Has client consented to this referral? Yes  No | |
| **REFERRAL DETAILS** | |
| Diagnosis: | |
| Reason for referral: | |
| Relevant Medical History: | |
| Relevant Social History: | |
| Other factors: *(such as hearing impairment, cognition, risk factors)* | |

|  |  |
| --- | --- |
| Clinical supporting documentation enclosed:  *Yes*  *N/A* Discharge/Health Summary  *Yes*  *N/A* Pathology results (HbA1c, FBGL, OGTT, lipids)  *Yes*  *N/A* GP Management Plan  *Yes*  *N/A* Specialist reports – Urology, Urogynaecology or Gynaecology, Endocrinology | |
| **CURRENT MEDICATIONS (including allergies)** | |
|  | |
| **REFERRER DETAILS** | |
| Referrer Name: | Telephone: |
| Referring Organisation: | Fax: |
| Referrer Provider No. (if applicable): | Date completed: |
| Referrer Email: | |
| Client’s GP (if referrer is not GP): | |

**INSULIN THERAPY ORDER**

*Please only complete* w*hen requesting support with insulin therapy,* ***GP must complete this section***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Type (s) of Insulin** | | | | **Starting Dose** | | | **Time and Regimen** |
|  | | | |  | | |  |
|  | | | |  | | |  |
|  | | | |  | | |  |
| **Target Blood Glucose Range:** | | | | Size of Incremental Adjustments: | | | |
| Fasting: | | | Post Prandial: |
| **Case Management for Client Commencing Insulin Therapy in the Ambulatory Setting:**  Please tick the appropriate section otherwise referral is INVALID  *Referring doctor wishes Diabetes educator to adjust insulin doses until BG targets achieved*  *Referring doctor will adjust insulin doses.* | | | | | | | |
| Referring Doctor: |  | | | Work Phone: | |  | |
| Practice: |  | | | Mobile: | |  | |
| Address: |  | | | Email: | |  | |
| Postcode: |  | | |  | | |  |
| **Doctor’s Signature:** | |  | | Date: |  | | |

**Please complete and fax individual referral to 1300 601 788**

**or email** [**SCReferrals@silverchain.org.au**](mailto:SCReferrals@silverchain.org.au)