

**REFERRAL FORM**

**SWINDON COMMUNITY DIABETES SERVICE**

**e-mail:** **SWICCG.CommunityDiabetesService@nhs.net**

**Tel: 01793 696621 Fax: 01793 487435**

 Rapid Access Home Visit Joint Consultant/Gp practice based clinic Joint DSN practice based clinic

|  |  |
| --- | --- |
| Patient Information: | NHS number: |
| Name: |  |
| DOB |  |
| Address |  |
| Date Of Diabetes Diagnosis:  | **Type 1 Type 2** |
| Diabetes Education |
| DESMOND, LIFT Psychology,Weight Management, Steps to Health,Dietbusters, Living with diabetes living Well(please circle as appropriate) | **Date attended:** |
| Diabetes Essentials | **Date** | **Results** |
| BMI |  |  |
| Weight |  |  |
| Blood pressure |  |  |
| Last Foot Check |  |  |
| Last Retinal Screening |  |  |
| Blood Tests | **Date** | **Result** | **Date** | **Result** |
| HbA1c |  |  |  |  |
| Creatinine |  |  |  |  |
| eGFR |  |  |  |  |
| Total cholesterol |  |  |  |  |
| Triglycerides |  |  |  |  |
| Non-HDL |  |  |  |  |
| HDL |  |  |  |  |
| Urine Tests | **Date** | **Result** |  |  |
| Albumin/creatinine ratio |  |  |  |  |
| Is the patient under specialist Yes NoDiabetes clinic at GWH? |
| Comorbidities |
|  |
| Current anti-diabetes therapy (agent, dose, the date of initiation) |
|  |
| Previous anti-diabetes therapy (length of rx, reasons for stopping) |
|  |
| Repeat list of medications (to be attached) |
|  |
| Reason for referral – please state clearly the reasons for referring this patient |
|  |
| Referrer (print name) | **Tel no:** | **Date:** |
| GP | **Name of the practice** |  |