

**REFERRAL FORM**

**SWINDON COMMUNITY DIABETES SERVICE**

**e-mail:** [**SWICCG.CommunityDiabetesService@nhs.net**](mailto:SWICCG.CommunityDiabetesService@nhs.net)

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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 No  Diabetes 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** | | | | |  | |