

# DIABETES ALLIED HEALTH CLINIC REFERRAL

Date of referral \_\_\_\_\_

Person making referral \_\_\_\_\_

Consultant \_\_\_\_\_

UR Label

## DIABETES EDUCATION

**Type 1 Diabetes**                       **Type 2 Diabetes**                       **Other ( Specify)**

- Self management education
- Two consecutive HBA1c greater than 10%
- Change to insulin regime (specify below)
- Commencing insulin
- School camp planning
- Starting/ Changing School
- Overseas travel
- Transfer from/ to another health service

\* Please note insulin pump referrals require a separate form.

## SOCIAL WORK

- Issues with adherence to diabetes self-care management (including FTAs)
- Family stress/ difficulties / lack of support systems
- High levels of anxiety/behavioral issues (child and/or parent/s)
- School issues impacting on diabetes management
- Risk-taking behaviors
- Child welfare/history of protective concerns\*

\* New protective issues to be referred to the Gatehouse Centre (Ext: 6391)

**NUTRITION REVIEW**

Additional information related to referral

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**APPOINTMENT DATE:**

To be seen - please circle:

**1 – 2 weeks**

**1month**

**Next Available**