HealthPathways SOUTH WESTERN SYDNEY

Diabetes Referral Letter

Referring Doctor:	Phone:
Address:	Fax:
	Email:

Patient Details

Name:	Smoker: Yes / No
Address:	Interpreter required? Yes / No
Phone Number:	If Yes, Language:

Required Information

HbA1c Results:

Duration of diabetes:

Diabetes medication:

Cardiovascular Risk Category:	Yes / No	If Yes, details:
Lipid lowering therapy:	Yes / No	If Yes, details:
BP lowering therapy:	Yes / No	If Yes, details:
Anti-platelet therapy:	Yes / No	If Yes, details:
Significant co-morbidities:	Yes / No	If Yes, details:
Episodes of hypoglycaemia:	Yes / No	If Yes, details:
Self-monitored BSL:	Yes / No	If Yes, details:
End organ damage:	Yes / No	If Yes, details:

Individualised HbA1c Target:

Carer assisting in management:

Agreed Coordinating Health Practitioner:

Please attached the following test results if available:

- Fasting BSL
- T Chol
- Triglycerides
- HDL-C
- LDL-C
- eGFR
- Albumin:Creatinine Ratio (ACR)
- BP

Additional Comments:

Signature: Date: