

# Southern Highlands Diabetes Programs Referral Form

ID:

REFER TO:  Diabetes Program OR  Division Pre-diabetes Program OR  Live Life Well Diabetes Prevention Program

**Patient details:** Please use a black pen and write clearly.

Surname:

First name:

Date of birth:  /  /  Male  Female

Address:

Phone (day):

Mobile:

Email:

Country of birth:

Language used at home:

Aboriginal: Yes  No  Torres Strait Islander: Yes  No

**Clinical information for all Programs:**

Diabetes Risk Score:

Blood Pressure:

Fasting Plasma Glucose (FPG):  Date:

OGTT (if applicable) Fasting:  2hr pp:  Date:

Lipids: Total Cholesterol:  TG:

HDL:  LDL:

Height (cm):

Weight (clothed) (kg):

Waist circumference (cm):

**Medications:** Please attach list.

**Past medical history:** Please attach list.

## Diabetes Program or Division Pre-diabetes Program

- Type 1  PCOD  
 Type 2  IGT  
 GDM

Date of diagnosis

**Attach diabetes complications list.**

Appointment needed with Diabetes Educator: Yes  No

**Current therapy:**  Diet  Insulin  
 OHA  Insulin and OHA

**Family history:**  Diabetes  
 Hypertension  
 Cardio-vascular disease  
 Stroke

**Lifestyle risk factors:**

Smoking: Yes  No  Cigs/day  Year ceased

**Nutrition:**  Low fat  
 Low salt  
 Weight reduction  
 Diabetic specific

**Alcohol:** Standard drinks per week   
Alcohol free days per week

**Physical activity:**  Adequate  Inadequate  Sedentary  
Total minutes per week

## Live Life Well Diabetes Prevention Program

Medical contraindications:

- The patient is ineligible because the patient:
- is taking or has taken Metformin or other hypoglycaemic medication in the past month
  - is taking prescribed weight loss medication
  - has one or more of the following conditions:
    - Type 1 or 2 diabetes
    - Pregnancy
    - Untreated severe aortic stenosis or other structural heart disease
    - End-stage congestive heart failure
    - Progressive or terminal cancer
    - Severe cognitive impairment or behavioural disturbance
    - Malignant arrhythmias
    - Unstable abdominal, thoracic or cerebral aneurysm
    - Unstable CAD
    - Other

The patient has declined to participate

The patient has agreed to participate

Please note any conditions that may affect the patient's ability to participate in exercise:

Please ensure that the patient signs the Consent on the reverse side.

**Form continues over →**

## GP details

GP name: \_\_\_\_\_

GP phone: \_\_\_\_\_

or GP stamp:

**Remember to attach medications and past medical history lists and, if applicable, diabetes complications list.**

## Consent for Diabetes Programs

I, \_\_\_\_\_

(Name printed in full)

Date of birth \_\_\_\_\_

of \_\_\_\_\_

(Address)

Have read and understood the Diabetes Programs Information Sheet.

### I hereby consent to:

1. Participate in the following Program as ticked:

The Southern Highlands Diabetes Care Program;

The Southern Highlands Pre-diabetes Program;

The *Live Life Well* Diabetes Prevention Program.

2. Allow my relevant data to be entered into a secure database.

I understand that my participation in this Program will allow authorised Program staff to access my data which will be held on a strictly confidential and need to know basis. I also understand that my data will be used for the above selected Program only.

3. If applicable, allow results from the *Live Life Well* Program to be presented at a conference or for scientific publication.

I understand individual participants will not be identifiable in such a presentation.

My consent is conditional on my right to withdraw from the Program, access my data or have my data withdrawn from all databases at any time.

\_\_\_\_\_

(Patient's signature)

\_\_\_\_\_

(Date)

The above selected Program has been explained to me by:

Dr. \_\_\_\_\_

\_\_\_\_\_

(Doctor's signature)