Government of South Australia
SA Health

SALHN GP PLUS
DIABETES OUT OF HOSPITAL SERVICE REFERRAL

Facility/Site: .....

SA Health UR No: .....
Surname: .....
Given Name: .....
Second Given Name: .....
D.O.B: ..... Sex/Gender .....

Referrals to be faxed to Fax: (08) 8164 9199 **Phone enquiries can be directed to Phone: (08) 8164 9111 (opt 1)**

REFERRAL TO

Discipline required	☐ Diabetes Nurse Educator ☐ Diabetes Dietitian

REFERRER INFORMATION

Referrer's name		Phone number	
Practice Name / Department / Ward		Position / Discipline	
Address			
Referrer email		Date	
Patient consent to referral	☐ Yes ☐ No		

GENERAL PRACTITIONER DETAILS (if not referrer)

Doctor's name		Surgery name	
Surgery address, phone and fax			

PATIENT DETAILS

Address (or address where care will be provided for home visiting)			
Preferred phone		Alternative phone	
Medicare number		Expiry date	
Is the patient of Aboriginal or Torres Straight Islander origin?	☐ No, neither ☐ Yes, Torres Strait Islander ☐ Yes, Aboriginal ☐ Yes, both		
Is an interpreter required?	☐ Yes ☐ No	Language	
Does the patient have a carer	☐ Yes ☐ No	Relationship to patient	
Carer name		Phone number	
Existing or new services	☐ NDIS ☐ Home Care Package ☐ RDNS ☐ MRU ☐ Other Details:		
Other considerations & patient requirements	eg. Visually impaired, literacy level, social situation		

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REFERRAL INFORMATION

Type of Diabetes	☐ Type 1 ☐ Type 2 ☐ Type 3C ☐ Corticosteroid Induced ☐ Other _____ Year of diagnosis : _____
* Reason for referral	☐ New or suspected diagnosis of Type 1 Diabetes /LADA ☐ New diagnosis of Type 3c Diabetes ☐ Severe hypoglycaemia (requiring the assistance of a 3rd party to treat) ☐ Recurrent hypoglycaemia ☐ Recent admission for Diabetes Ketoacidosis (DKA) ☐ Recent admission for hyperosmolar hyperglycaemic state (HHS) ☐ Recent unexplained hyperglycaemia > 20mmol/L > 7 days ☐ Urgent insulin titration for corticosteroid therapy ☐ Pump failure without alternative plan in place ☐ Recent hospitalisation without inpatient Endocrine review OR ☐ Other
* Details of referral	
Past medical history	
Current medications (Including GLP1s, Oral Hypoglycaemics)	
If on Insulin please provide name, dose, frequency and route	☐ Insulin start ☐ Insulin Change ☐ Existing Details: ☐ Insulin to Carb Ratio _____ ☐ Insulin Sensitivity Factor _____
Titration Order	Permission to Titrate Insulin according to SALHN standing orders: ☐ Yes ☐ No
Instructions regarding other oral or injectable diabetes medications	
* Pathology	(Attachments to be included with referral): ☐ HbA1c _____ If HbA1c is not provided, reason:_____ ☐ For newly diagnosed Type 2 Diabetes, diagnostic pathology to be included ☐ Other (i.e. Biochem, including renal function, lipids): _____
If currently an Inpatient planned discharge date	Please only submit when patient is discharged home or to place of residence Date: _____

Please attach any relevant results, pathology, medication and past medical history
* To enable this form to be actioned please ensure the following mandatory fields have been completed