**Type 1 Diabetes Education**

Please refer to the Devon Formulary and Referral website for helpful primary care information for management of referrals to Diabetes Education Programmes

 <http://southwest.devonformularyguidance.nhs.uk/>

|  |  |
| --- | --- |
| Referring GP: | <GP Name> |
| Practice Name: | <Organisation Address> |
| Practice Address: | <Organisation Address> |
| Telephone: | <Organisation Details> |
| Fax: | <Organisation Details> |
| Ref: |       |

Request Type:Advice/Referral Date of Referral: **<Today's date>**

Specialty:

Dear Colleague

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Surname:  | **<Patient Name>** | Date of Birth:  | **<Date of Birth>** |
| Forename(s):  | **<Patient Name>** | Gender:  | **<Gender>** | Ethnicity: | **<Ethnicity>** |
| Address (inc postcode): **<Patient Address>** | **NHS Number:** **<NHS number>** | **UBRN** |
|  |  |
| Preferred Tel No: | **<Patient Contact Details>** |
| Tel No (Home): | **<Patient Contact Details>** | Tel No (Mobile):  | **<Patient Contact Details>** |
| Patient’s email: | **<Patient Contact Details>** |

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| **Patient Information:** *Please answer the questions below:* |
| Does your patient have needs that you feel might be able to be accommodated with reasonable adjustments to normal outpatient clinic arrangements? i.e. downstairs, wide door access, no lifts |       |
| Does your patient have a cognitive impairment e.g. learning disability, dementia? |       |
| Does your patient have a sensory impairment? |       |
| Does your patient have a physical impairment? |       |
| Name of Carer/Family Member/Friend (if applicable) |       |
| Is an interpreter required? If yes please state language |       |

**Primary Reason for Referral:** *(Please be as specific as possible required by Optimising Referrals LES)*

**Referral Letter:** *(Include any advice or management plans, or attach physio/ESP referral letter)*

Yours faithfully,

<Sender Name>

**Relevant Past Medical History:** *If none please state* (*Required for Optimising Referrals LES)*

<Problems(table)>

<Summary(table)>

**Current Medication:** *If none please state* (*Required for Optimising Referrals LES)*

<Medication(table)>

**Allergies:** *Medication or other adverse effects – If none please state* (*Required for Optimising Referrals LES*

<Allergies & Sensitivities(table)>

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| --- |
| **Referral Metrics:** (Please include latest results where available) |
| **Body Mass Index (BMI)**  | <Numerics> |
| **Blood Pressure** | <Blood Pressure Configurable> |
| **Smoking Status**  | <Diagnoses> |
| **Pulse** | <Numerics> |
| **Haemoglobin** | <Numerics> |
| **HbA1c**  | <Numerics> |
| **Date of Diagnosis** |  |
| **Cholesterol** |  |