**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>** | | | | | | |

|  |  |
| --- | --- |
| **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)>

|  |  |
| --- | --- |
| **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** |  |