**Type 2 Diabetes Education Referral Form**

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> |
| Ref: |       |

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

Specialty:

Patient Surname: <Patient Name>

Forename(s): <Patient Name>

Address: <Patient Address>

Date of Birth: <Date of Birth>

Gender: <Gender>

Ethnicity: <Ethnicity>

NHS No: <NHS number>

Preferred Tel No: <Patient Contact Details>

Tel No (home): <Patient Contact Details>

Tel No (mobile): <Patient Contact Details>

Patients 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 |       |

**Relevant Past Medical History:**

<Problems(table)>

<Summary(table)>

**Current Medication:**

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