

Community Support Services Referral Form

Referrer Name: Place of Practice: Date of referral:	Do you have client permission to share this information? Yes <input type="checkbox"/> No <input type="checkbox"/> (Please obtain before proceeding)	Diagnosis: <input type="checkbox"/> Type one <input type="checkbox"/> Type two <input type="checkbox"/> Pre-diabetes <input type="checkbox"/> Other
Name of Client: Whanau Contact:	DOB: Age: Iwi/Ethnicity: Usual GP:	Address: Phone No. Email: NHI:
<p>Relevant Clinical Information: (i.e. HbA1c, date of diagnosis, medications, BMI, blood pressure, lipids, urine micro albumin/eGFR, (ACR), retinal, feet & smoking status, allergies, co-morbidities). Please include or attach relevant Non-Clinical Information ((i.e. disability, social support, learning difficulties etc.) Please include clinical notes where possible:</p>		
Reason for Referral: <ul style="list-style-type: none"> <input type="checkbox"/> Requested by client <input type="checkbox"/> General support to manage/understand diabetes (Complete specific requests above) <input type="checkbox"/> Follow up to underpin GP/Nurse input <input type="checkbox"/> DESMOND (Diabetes Education Program) <input type="checkbox"/> Advocacy/Counselling Services <input type="checkbox"/> Info re: other diabetes services /programmes <input type="checkbox"/> Info re: joining Diabetes Help Tauranga <input type="checkbox"/> Info re: local diabetes network/support groups <input type="checkbox"/> Support/Info for whanau/friends <input type="checkbox"/> Clinical Education for carers/nurses <input type="checkbox"/> Other (please describe above) 	Areas of Concern: <ul style="list-style-type: none"> <input type="checkbox"/> Micro/macrovascular complications <input type="checkbox"/> Insulin/medication administration <input type="checkbox"/> Blood glucose monitoring <input type="checkbox"/> Lifestyle Choices <input type="checkbox"/> Medication adherence <input type="checkbox"/> Hypo management <input type="checkbox"/> Hyperglycaemia/sick day management <input type="checkbox"/> Other (as above) 	
<p>Please post, fax, or email completed referrals - details above</p>		<p>All information is held in full confidence as per the Privacy Act (1993), Health Information Privacy Code (1994), Health & Disability Code (1996), Health Practitioner Competence Act (2003) & Health & Safety at Work Act 2016</p> <p>This information is privileged. If you are not the intended recipient, please inform Diabetes Help Tauranga (DHT) immediately, & destroy this document. DHT is not responsible for any illegal changes made to this document.</p>