**CHO 9 Community Diabetes Dietitian Referral Form (Primary Care)**

**Type 2 Diabetes only**

**Patient Details Referrer Details**

|  |  |
| --- | --- |
| (**Place Patient Sticker or Complete sections below**)**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Contact phone number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Is an interpreter required** Yes **€** No **€** **Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Date of referral­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Referring Professional** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Name of referring professional:** **Contact number/bleep** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**GP Name and Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**If under a diabetes consultant please state name of consultant**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |
| --- | --- | --- |
| **Referral for Structured Group Education** | **Tick ONE box below only** | **Email to: referrals.nd@hse.ie** |
| Structured Group Education | DESMOND - **6 hours** of education in a small group over 1 full day or 2 half days in a community venue- Delivered by the Community Diabetes Dietitian and Clinical Nurse Specialist (Diabetes) |  |
| **OR** DISCOVER DIABETES* 2.5 hours of education in a small group, once per week for 4 weeks (**10 hours in total**) in a community venue, follow up group session at 6 months and 12 months
* Delivered by the Community Dietitian
 |  |

**THOSE WHO ARE NOT SUITABLE FOR DESMOND OR DISCOVER DIABETES- Offer 1:1 clinic appointment with Community Diabetes Dietitian. Please fill out the table below**

|  |
| --- |
| **Reason for 1:1 appointment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Newly diagnosed Type 2 Diabetes? YES € NO €** **Please tick as appropriate** |
| **Past Medical History:**  |
| **Medications frequency and dosage:**  |
| **Additional information/ risks:**  |
| **Biochemistry** | Total Cholesterol | HDL | LDL | Triglycerides |
| HBa1c | ACR | Date:  | Weight and BMI (if known):  Date: |
| **CONSENT (Complete for 1:1 clinic appointment referrals only)**Has the patient consented to this referral? **YES € NO €**Has this patient consented to his/ her information to be shared? **YES € NO €** |

**If any queries, contact:**

Orlaith Burkett, Community Diabetes Dietitian

**Telephone:** 8953744

**Email:** orlaith.burkett@hse.ie

**Community referrals:**

**Email completed forms to:** **referrals.nd@hse.ie**

**Please note incomplete forms will be returned to the referrer.**