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

**Type 2 Diabetes only**

**Patient Details Referrer Details**

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| (**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**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **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**

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| **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**](mailto:referrals.nd@hse.ie)

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