



Queensland  
Government

## Attention: Chronic Disease Bayside Diabetes

Fax: (07) 3488 4303

Phone: (07) 3488 4222

### REFERRAL TO: Chronic Disease Bayside Diabetes

To access the service please complete the referral details below and forward by fax to the above contact details. An alternative form, which includes the same information e.g. RACGP form, may be used if preferred.

#### CLIENT DETAILS

Referral Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Preferred Title: Mr  Mrs  Ms  Miss

Name: \_\_\_\_\_ Male  Female

Address: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone: \_\_\_\_\_

Mobile: \_\_\_\_\_

Indigenous Status: Aboriginal  Torres Strait Islander  Both  Neither  Not Stated

Country of Birth: \_\_\_\_\_ Language: \_\_\_\_\_

Interpreter required: Yes  No

Doctor: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date Diagnosed: \_\_\_\_/\_\_\_\_/\_\_\_\_ Type of Diabetes: IFG/IGT  GDM  Type 1  Type 2

Individual Health professional requested: \_\_\_\_\_

Relevant Medical History (including complications): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_

FBG: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ OGTT: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

HbA1c: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ ELFT: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Total Cholesterol \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ TG: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

HDL: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ LDL: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Referrer: *(please print or stamp)* \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_