Moorditj Djena Referral Form - Podiatry & Diabetes Education Program

Eligible clients must be of Aboriginal / Torres Strait Islander descent and 18+Years of Age

PATIENT DETAILS

Surname:	First:
Address:	
Post Code:	Phone:
URMN:	DOB: / /
☐ Male ☐ Female	Country of Birth:
Aboriginal ☐ Yes Torres Strait Islander ☐ Yes	
Interpreter Required ☐ Yes ☐ No	
Visual Impairment ☐ Yes ☐ No	
Hearing Impairment ☐ Yes ☐ No	
Alternative Contact Name:	
Alternative Contact Phone:	

REFERRER

Name	
Organisation	
Address	
Post Code	Phone

GP DETAILS (if different to above)

Name:	
GP Practice:	
Address:	
Post Code:	Phone:
Fax:	

REFERRAL TYPE

☐ **Podiatry**
- ☐ Neuro Vascular assessment
- ☐ Footwear assessment
- ☐ Ulcer / wound assessment
- ☐ Nail Surgery assessment
- ☐ Diabetes Foot education

☐ **Diabetes Educator**
- ☐ HbA1c ≥ 8 or > or 64 mmol / mol
- ☐ Insulin Initiation and / or Stabilisation
- ☐ Blood glucose monitoring
- ☐ Gestational diabetes (GDM)
- ☐ Improved blood lipids / blood pressure
- ☐ Kidney disease / dialysis

Other: _____

Additional Information

Need Transport ☐ Yes ☐ No

MEDICAL CONDITIONS

☐ Heart disease ☐ High blood pressure
☐ Peripheral neuropathy ☐ Peripheral arterial disease
☐ Diabetes Type _____ Year of Diagnosis _____
☐ Kidney disease Stage _____
☐ Dialysis Type: _____
Other: _____

Current Medications ☐ Yes ☐ No
If yes, please attached current list ☐ Attached

Allergies/ Alerts: _____

PATHOLOGY RESULTS

Copies attached ☐ Yes ☐ No			Date
Blood Pressure		mmHG	
HbA1c		% / mmol/mol	
Lipids Total-C Trig HDL-C LDL-C	 _____ _____ _____ _____	mmol/L	
Microalbuminurea		Mg/L	
Alb/Creat Ratio (ACR)		Mg/mmol/L	
eGFR		mL/min	

* Note: We do not require a GPMP / TCA to accept patient referrals.

Name:	Signature:	Date: / /

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