Shape

Description automatically generated with medium confidence

**East Riding Community Diabetes Service**

**Referral Form**

**\*Please Note: Incomplete forms will be returned, resulting on delayed assessment\***

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Referrer: | | | | | | | | | | | Date of Referral: |
| Job Title: | | | | | | | | | | | |
| Address & contact number/email: | | | | | | | | | | | |
| **PATIENT DETAILS** | | | | | | | | | | | |
| Registered GP: | | | | | | | | GP Practice Address: | | | |
| Telephone Number: | | | | | | | |
| Title: | Forename: | | | | | | | Surname: | | Known as: | |
| Date of Birth: | | Unit No: | | | | | | NHS Number: | | | |
| Gender: | | | | | | | | Ethnicity: | | | |
| Religion: | | | |
| Address: | | | | | | | | | | | |
| Patient Home Telephone Number: | | | | | | | | Patient Mobile Number: | | | |
| Preferred contact number: Home  Mobile | | | | | | | | Email address: | | | |
| Lives alone/carers/nursing home/  residential home: | | | | | | | | Next of Kin/Carer/Emergency contact: | | | |
| Consent to contact via SMS & Email | | | | | | | | Yes | | No | |
| Consent to contact via SMS & Email | | | | | | | | Yes | | No | |
| Translator required: | | | | Yes | | No | | Language required: | | | |
| Accessible information needs: | | | | Yes | | No | | Detail needs: | | | |
| Diagnosis: | | | | Client aware of diagnosis? | | Yes | | No | | | |
| Are there any other services involved in patient’s care | | | | Yes | | No | | Don’t know | | | |
| **SUPPORTING INFORMATION** | | | | | | | | | | | |
| Is there a Lone working risk? | | | | | | | | Yes | | No | |
| Is there a Safeguarding risk? | | | | | | | | Yes | | No | |
| Has the patient given consent for the referral? | | | | | | | | Yes | | No | |
| Any concerns re Mental Capacity? | | | | | | | | Yes | | No | |
| **ReSPECT** document in place? | | | | | Yes | | | No | | **(If yes give details)** | |
| Smoking: | | | Yes | | | No | | | | Don’t know | |
| HbA1c: (please give dates) Latest:  Previous: | | | | | | | | | | | |
| Diagnosis Date: | | | | | | | | | Other conditions and relevant social considerations: | | |
| Current Medication: | | | | | | | | |
| Reason for Referral:  New Type 1  Therapy optimisation  Out of target blood glucose control  Carbohydrate counting | | | | | | | | | | | |
| Weight: | | | | | | | eGFR: | | | | |
| Height: | | | | | | | Serum creatinine: | | | | |
| BMI: | | | | | | | Triglycerides: | | | | |
| Date: | | | | | | | Signed: | | | | |

Send completed forms to: Diabetes Specialist Nurse, Bridlington and District Hospital, Bessingby Road, Bridlington, YO16 4QP or email [chcp.erspecialistdiabetesservices@nhs.net](mailto:chcp.erspecialistdiabetesservices@nhs.net)

\* **Please note it is CHCP Policy that a family member or friend cannot be used for translation purposes\***