

## What next?

A DCAS health professional will telephone the patient and coordinate the appropriate services. You will be faxed a 'GP Referral Feedback Form' that lists the services that your patient has agreed to attend.

## Making a difference

Since 2002 more than 520 general practitioners have referred over 4600 patients into DCAS.

- Evaluation of the Diabetes Cardiovascular Risk Management Program showed:

- 1% reduction in HbA1c from baseline to year 1 (p = 0.50)
- Significant increase in HDL (p = .007)
- Significant increase in patient's ability to access appropriate support
- Reduction of \$1700 per participant hospitalization cost

2005

- Evaluation of the Integrated Diabetes Project for newly diagnosed patients found significant improvement in:

- HbA1c
- Frequency of physical activity
- Patients understanding of how best to manage their diabetes
- Patients health and wellbeing

2004

## Testimonials

*"Aggressive and early treatment of diabetes is very important. Understanding cultural barriers is also essential. My patients who have attended the course have improved their understanding of diabetes, thus achieving better compliance."*  
(GP in Narre Warren)

*"The DCAS staff know how to relate to GPs, I am confident the service combines assisting the welfare of the patient while supporting the GP role. It is a great conduit to appropriate patient services."*  
(GP in Dandenong)

*"I like the feedback from DCAS as it compliments the recall and reminder systems in place at the practice."*  
(Practice nurse in Berwick)

*"The course was excellent, it helped me develop more confidence in handling my diabetes. Sharing experiences within the groups helped to lighten the load, it is no longer a*

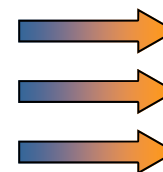
## Information for General Practice

# Type 2 Diabetes Patient Services

The **Diabetes Co-ordination and Assessment Service (DCAS)** is the Division's centre for all diabetes enquiries.  
**Phone: 8792 1922 Fax: 9793 9052.**

Services include:

- Self-management education provided by allied health professionals
- Specialist advice



**About the service**

**How to refer**

**Information required**

## About the service

The Division supports general practice teams to provide most of the medical care to people with type 2 diabetes, with timely referrals to community and hospital based services. Type 2 diabetes patient services include:

### ■ Self-management education courses

Allied health professionals including diabetes educators, dietitians and podiatrists conduct group education courses. These are available for patients **at any stage of diabetes**, including those:

- At risk of developing diabetes and / or pre-diabetes
- With newly diagnosed or established type 2 diabetes
- With type 2 diabetes who are at risk of or have cardiovascular disease.

Courses teach participants about diabetes and self-care. Topics covered include healthy eating, physical activity, foot care, and blood glucose monitoring. The groups are conducted at local community sites in a series of sessions (e.g. four, weekly group sessions). Individual sessions are available for patients who require an interpreter or whose needs cannot be met in group sessions. A small fee applies for all sessions.



### ■ Specialist advice

The Diabetes Cardiovascular Advisory Clinic (DCAC) is designed to support general practice teams with the management of patients who have complex needs. **The general practitioner continues to be the primary care coordinator.** The Clinic is for adults with type 2 diabetes who are at risk of or have cardiovascular disease. It is based at the Dandenong Hospital and is staffed by a team including an endocrinologist, dietitian and a diabetes clinical nurse consultant. The clinic team also has the capacity to facilitate insulin initiation and stabilization where indicated.

## How to refer

Send DCAS a completed Victorian Statewide Referral Form **\*\* (VSRF) with clinical information.**

DCAS will then assess and triage your patient into the appropriate services based on clinical risk and assessment information.

## Information Required

### ■ Type 2 Diabetes

The VSRF must include:

- Date of diagnosis
- Relevant blood results
  - FBG/OGTT (for newly Diagnosed only)
  - HbA1c
  - Total Cholesterol, HDL, LDL, triglycerides
- Risk factors
  - BP
  - Smoking status
  - Height, weight and BMI
- Medication and medical history

■ If a GP Management plan has been prepared, please attach

### ■ Diabetes Prevention

The VSRF must include:

- Relevant blood results
  - FBG
  - OGTT (if indicated due to fasting level)
  - Total Cholesterol, HDL, LDL, triglycerides
- Risk factors
  - BP
  - Height, weight and waist measurement
  - Smoking status
- Medication and medical history



*Fax  
referral  
to  
DCAS on  
9793 9052  
or remit  
via Argus  
e-referral*

What Next

\*\*VSRF can be obtained online at [www.dcgpa.com.au/resources/Health\\_Programs/Diabetes](http://www.dcgpa.com.au/resources/Health_Programs/Diabetes) click on Referral Forms or by telephoning 8792-1922 or emailing DCAS at [admin@dcgpa.com.au](mailto:admin@dcgpa.com.au)