

# GP Referral

Referral Date: .....

GP Review Date: .....

Feedback Requested (please circle): YES / NO

**Referral to:**  
 Diabetes Co-ordination and Assessment Service (DCAS)  
 at the DDDGP  
 314B Thomas St, Dandenong 3175  
 Tel: (03) 9792 1550 Fax: (03) 97963 4050

**Referring General Practitioner** (stamp):

**Service requested:** Type 2 Diabetes Program & Services

**Patient / client details:**

Name: ..... Address:.....  
 Date of Birth: .....  
 Preferred name/s: ..... Phone: ..... work: .....  
 Sex (please circle): Male / Female Mobile: .....  
 Title (please circle): Mr, Mrs, Ms, Miss Email: .....  
 Alternative Contact: .....

**Reason for patient referral:**

**Other Notes (eg current services ):**

Interpreter required: ..... DVA Number: .....

Preferred language is: ..... Insurance: .....

Pension Card Number: ..... Medicare Number: .....

**Consent to referral and sharing of relevant information** (please circle): YES / NO

Attach 'Patient Consent Form' if restrictions apply.

# Clinical Information:

**Warnings:** .....

**Allergies:** .....

**Current Medication:**

Drug name	Ltd. elapse	Strength	Dose / frequency / special

**Social History:**

**Past Medical History:**

**Investigation / test Results:**

Date of Diagnosis: \_\_\_\_\_

	RESULTS	DATE
RBG / FBG	_____	_____
2 hr OGTT	_____	_____

HbA1C

\_\_\_\_\_

Cholesterol -

total \_\_\_\_\_ Trigs \_\_\_\_\_ LDL \_\_\_\_\_ HDL \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ Smoker: YES / NO \_\_\_\_\_

Height : \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_

Family History of Heart Disease / High Cholesterol :

GP SIGNATURE :

PROVIDER NUMBER :