Community Diabetes Nurse Referral Form SE and MID Highland

**Patient’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CHI Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s contact phone number/s\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Person Referring:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Status: GP / PN / Other\_\_\_\_\_\_\_\_\_\_Referring Practice­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_**

**Referral Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are there any Risks re Lone working Yes / No**

**Are there any risks associated to violence and aggression with seeing this patient Yes / No**

**If yes, please specify**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for referral: Please ensure patient is blood glucose testing prior to referral**

**Past medical history:**

**Current Diabetes Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Any Contra-indicated Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BMI:\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_ Latest HbA1c:\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please email completed form to: nhsh.communitydiabetesnurses@nhs.scot

**URGENT** referrals **MUST** be **Tel:** 01463 704625 **Mob:** 07748761674

phoned through

  **Community Diabetes Nurse Team**

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| **Claire Henderson-Hughes****Advanced Practice CDN/Team Lead****Tel: 01463 704625****Mob:07748761674****Email:**claire.henderson-hughes@nhs.scot | **Fiona Wilson****Senior Practitioner CDN – South East****Tel:** 01463 704631**Mob:** 07748761728**Email:**fiona.wilson45@nhs.scot | **Barry Gunn****Senior Practitioner CDN – South East****Tel:** 01463 704631**Mob:** 07972621415**Email:** barry.gunn@nhs.scot | **Tracey Roe****Senior Practitioner CDN – MID**  **Tel:** 01349 852496 ext 7398**Mob:** 07966140586**E-mail:** tracey.roe3@nhs.scot |