

Nepean Diabetes Service

Level 3 West Block, Nepean Hospital
Cnr Derby and Somerset St, Kingswood NSW 2747
PO Box 63, Penrith NSW 2751
Ph: 4734 3974 Fax: 4734 3979
NBMLHD-Nepeandiabetes@health.nsw.gov.au



Health
Nepean Blue Mountains
Local Health District

SECTION 1: Specialists available in this department:

Nepean Diabetes Service Dr Ivan Kuo (or another endocrinologist) General Clinic (any available practitioner)

THIS IS AN INDEFINITE REFERRAL (Please delete if not applicable)

ALL OUR SPECIALISTS BULK BILL DIRECTLY TO MEDICARE

SECTION 2: Patient Details

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Previous Surname/s: _____

Email: _____ Aboriginal Torres Strait Islander

Medicare No.: _____ NOK/Carer Name: _____

Relationship: _____ Phone number: _____

SECTION 3: Clinical Information

In addition to this referral please provide:

- A medical summary list
- A current medication list
- Recent pathology (<3 months old) including: **FBC, EUC, LFT, HbA1c, fasting lipids, urine ACR**
- Any other relevant scans / investigations **including documentation of criterion/criteria for entry that is/are indicated in reason for referral (see over)**
- **For pregnancy please use the Diabetes in Pregnancy Intake Form**

SECTION 4: Referral Information

- Referrals will be triaged in accordance with information you provide along with a medical summary, medication list and pathology etc. as listed above
- Your patient will be directed to the most relevant clinician based on their needs
- Your patient will see clinicians with experience in diabetes management, however they may not always see an Endocrinologist
- **We do not accept referrals for fitness to drive assessments**

Other clinicians already providing care outside of this service (please tick and provide name)

Endocrinologist _____ Diabetes Practice Nurse _____

Dietitian _____ Diabetes Educator _____

Podiatrist _____ Optometrist _____

Ophthalmologist _____ Diabetes Nurse Practitioner _____

Psychiatrist _____ Psychologist _____

Other _____

Referring Doctor:

Name/Provider Number: _____

Practice/Position _____

Date: ____ / ____ / ____ Signature: _____

Phone: _____ Fax: _____

Nepean Diabetes Service

Level 3 West Block, Nepean Hospital
Cnr Derby and Somerset St, Kingswood NSW 2747
PO Box 63, Penrith NSW 2751
Ph: 4734 3974 Fax: 4734 3979
NBMLHD-Nepeandiabetes@health.nsw.gov.au



Health
Nepean Blue Mountains
Local Health District

Reason for referral:

- Recent discharge from hospital** with a change to insulin regimen
- Type 1 diabetes:** date of diagnosis: ____ / ____ / ____
- Diabetes secondary to other condition(s)** e.g. Pancreatitis, Cystic Fibrosis, etc.
Please specify: _____
- CGM / Pumps – NDSS Subsidy Scheme**
- Type 2 diabetes** and meeting any of the criteria below:
 - < 40 years of age
 - HbA1c > 9.0% (75 mmol/mol)
 - On insulin and awaiting surgery and HbA1c > 7.5% (58 mmol/mol)
 - Using Insulin and ANY of the following:**
 - Insulin pump Basal /bolus Premixed
 - >2 units / kg >100 units / day
 - Body Mass Index (BMI) > 30 kg/m² and 5% weight gain within 6 months of starting insulin, ongoing weight gain
 - Hypoglycaemia** meeting **ANY** of the criteria below:
 - Recurrent blood glucose levels (BGLs) of < 4.0 mmol/L without reversible precipitant *OR*
 - Any history of unconscious hypoglycaemia *OR* Hypoglycaemia requiring hospital admission
 - Hyperglycaemia** (BGLs which are regularly > 15mmol/L or HbA1c > 8.0%), induced by steroids, novel anti-neoplastic (chemotherapy) / antiepileptic / antipsychotic agents
 - Premenopausal women planning pregnancy within 12 months**
 - Significant end organ dysfunction including:**
 - PVD* or Peripheral Neuropathy **AND** at high risk of ulcer / amputation or with history of ulcer / amputation
 - Retinopathy / macular oedema with history of intervention or threatened vision confirmed by Ophthalmologist
 - Severe albuminuria (ACR > 30mg/mmol Cr) or eGFR ≤ 30ml/min/1.73m²
 - Hospitalisation for heart failure or NYHA* Class II or greater (provide description of symptoms)
 - Severe liver fibrosis / cirrhosis on liver biopsy or ALT / AST > 5x normal presumed due to NAFLD / NASH
 - Other:** *If you think your patient is complex and requires review outside of the above criteria, you can provide a brief summary below. Please also provide a detailed referral with clear indication for review and this will be discussed with the multidisciplinary team (MDT) at the Diabetes Service.*

* PVD – Peripheral Vascular Disease, NYHA – New York Heart Association

SECTION 5: Triage (HOSPITAL USE ONLY)

Referral triaged: ____ / ____ / ____ by: _____ Signature: _____

For: Consultant Registrar/Resident

Category: 1 (30 days) 2 (<90 days) 3 (365 days) Appointment time: 15 mins 30 45 mins

Type: Group DNE Dietitian Endocrinologist Nurse Practitioner

For: Adult Transition Paediatrics Pre pregnancy planning

Appointment made: ____ / ____ / ____ at: _____

Entered in iPM: ____ / ____ / ____ by: _____