East Coast Area Diabetes Programme

PRE –DIABETES GROUP EDUCATION REFERRAL FORM

PATIENT DETAILS:

Title (*Mr/Mrs/Ms/other):* _____

First Name: _____

Surname: _____

Date of Birth: _____

Gender: Male: ☐ Female: ☐

Address: _____

_____

_____

_____

Telephone: Home: _____

Mobile: _____

Email Address: _____

REFERRER DETAILS:

Referred by: _____

Role (GP, Practice Nurse, CNS, Dietitian etc):

_____

Is GP aware of referral: Yes: ☐ No: ☐

Telephone No: _____

Patient's GP: _____

Practice Address: _____

_____

_____

Practice Telephone Number: _____

CLINICAL INFORMATION:

GLYCAEMIC STATUS ON REFERRAL FOR PRE-DIABETES GROUP EDUCATION:

Date: _____

Fasting Plasma Glucose: _____
(Parameters: 5.6-6.9)

Two Hour Post Prandial Glucose: _____
(Parameters: 7.8-11.0)

HbA1c: _____
(Parameters: 39-47)

Body Mass Index (BMI: kg/m^2) _____

Is this patient suitable for group education?

_____

_____

Any other relevant information:

_____

_____

Signature: _____

Please print name: _____

Date: _____

RETURN BY FAX, EMAIL OR POST TO:

Fax number: 01 2744289.
Email Address: roisin.kavanagh@hse.ie
Postal Address: Róisín Kavanagh, ECAD Administrator, HSE- CHE, Civic Centre, Bray, Co. Wicklow.

Please note: GP assistance may be required should any abnormal measurements relating to your patient be identified during the course of the education sessions.