Desmond — Diabetes Education and Self Management for Ongoing and Newly Diagnosed

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Clients Name: _____ M / F

Address: _____

_____

_____

D.O.B: _____ /_____ /_____

Telephone No (NB*): (H)(_____)_____ (M)(_____)_____

GP name: _____**GP address:**_____

_____

Newly Diagnosed (last 12 months) Yes/ No

Ongoing (If Longer than 12 months) Yes/ No

Client Consent for Referral: Yes/ No

Client Consent to Receive (Appointment reminder) Text alerts Yes/ No

_____

Clinical information required:

Date of appointment/visit:		
HbA1c (mmol/mol)		
Total cholesterol (mmol/l)		Fasting Yes/No
HDL (mmol/l)		
LDL (mmol/l)		
Triglycerides (mmol/l)		
Systolic BP (mmHg)		
Diastolic BP (mmHg)		
Weight (kg)		
Waist (cm)		
Smoking	Yes/No	

Referral Signature:…… G.P / Nurse / HP / Self

Contact Details:…… **Date**:……...

Please send/fax referral to: DESMOND Co-ordinator
Community Nutrition and Dietetic Service
North West Wing
St Josephs Hospital
Mulgrave St
Limerick

Phone: 061 461243
Fax: 061 446653

Version November 2019