Department of Health and Human Services
NORTH WEST DIABETES CENTRE

REFERRAL FORM

To: Dietitian ☐ Physiotherapy ☐
Podiatry ☐ Social Worker ☐
Eye Screening ☐ Diabetes Educator ☐
Psychologist ☐

Please send a copy of your initial findings to the referring professional.
Thank you

Date: ____________________

GP: ____________________

Patient Name Label

DETAILS OF DIABETES	
Year of Diagnosis & Type:	Most Recent HbA1c:
Complications of Diabetes:	
Other Medical History:	

LIFESTYLE	
Food/Diet:	
Occupation:	
Home Situation:	
Smokes (amount):	Alcohol Intake (amount):
Exercise Level:	

CURRENT MEDICATION
Diabetes Treatment

REASON FOR REFERRAL:
Referred by:

Client Consent: YES / NO