DIABETES PROGRAM
REFERRAL FORM

BLACK SWAN HEALTH LTD

Incomplete referral form may result in processing delays and impact on the client's care coordination
Please sign and submit the completed form to diabetes@blackswanhealth.com.au or fax to 9201 0033
Please refer to the Black Swan Health website for eligibility and exclusion criteria

BINDING MARGIN – NO WRITING

Date of referral: __ / ___ / 20___

1. CLIENT DETAILS

Title: _____ Gender: ☐ Male ☐ Female ☐ Other

Last Name: _____ First name(s): _____

D.O.B: ___ / ____ / _____ Access issues: _____

Address: _____

Suburb: _____ Postcode: _____

Mobile: _____ Home: _____ Email: _____

Emergency contact / Next of Kin name: _____ Phone: _____

Is the client of Aboriginal and/or Torres Strait Islander descent? ☐ Yes ☐ No

2. REFERRER DETAILS

☐ GP (Skip to Section 3 – GP details) ☐ Specialist ☐ Other _____

Referrer name: _____ Position: _____

Address: _____

Suburb: _____ Postcode: _____

Phone: _____ Fax: _____ Email: _____

3. GP DETAILS

GP's name: _____ GP Stamp:

GP's practice: _____

Address: _____

Suburb: _____ Postcode: _____

Phone: _____ Fax: _____ Email: _____

4. REFERRAL INFORMATION

Which type of Diabetes does you client have:

☐ Type 1 ☐ Type 2 ☐ Type 2 on Insulin ☐ IGT / IFG ☐ At risk of Type 2

☐ At risk / newly diagnosed CHD ☐ Microalbuminuria Date of diagnosis: __ / ___ / ____

Is the client registered with NDSS? ☐ Yes ☐ No

Is the client suitable for a Group Education session? ☐ Yes ☐ No

Black Swan Health Limited (ABN 64 169 929 677)
t: 08 9201 0044 **f:** 08 9201 0033 **e**: diabetes@blackswanhealth.com.au
Corporate office: 137-151 Main Street, Osborne Park, WA 6017
Service locations: Osborne Park | Joondalup | Midland | Fremantle
www.blackswanhealth.com.au

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Current treatment:

☐ Lifestyle only ☐ Lifestyle and tablets ☐ Lifestyle, tablets and insulin

☐ Lifestyle and insulin ☐ Other (please specify) _____

Current medication (or attach): _____

_____

Other relevant medical condition(s):

☐ Heart disease ☐ High Blood Pressure ☐ Kidney disease ☐ Eye problems

☐ Other (please specify) _____

Date of last Pathology Testing (within last 12 months): __ / ___ / 20___ (please attach report if available)

HbA1c _____ *mmol/mol* *OGTT (if newly diagnosed) (mmol/L)*

Urinary Microalbumin _____ *mg/L* *Fasting:* ___ *one hour:* _____ *two hour:* _____

ACR _____ *mg/mmol*

eGFR _____ *Blood Pressure:* _____/_____

Serum Creatinine _____ *micromol/L* *Other:* _____

Full Lipid Profile

Cholesterol _____ *mmol/L* *HDL* _____ *mmol/L*

TG _____ *mmol/L* *LDL* _____ *mmol/L*

5. CONSENT TO REFERRAL

Please tick the appropriate boxes below. Black Swan Health is only able to accept referrals where the client / guardian has consented to the referral, either verbally or in writing.

☐ I consent to be referred to Black Swan Health

Client / guardian signature: _____ Date: __ / ___ / 20___

Print Name: _____

☐ I confirm my client has been assessed and meets the eligibility criteria for a referral to Black Swan Health

☐ I have obtained verbal consent from the client / legal guardian to refer and provide their personal health information to Black Swan Health for further assessment

Referrer's signature: _____ Date: __ / ___ / 20___

Print Name: _____

OFFICE USE ONLY – leave blank
Unique client number (Black Swan Health to generate): _____

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