Diabetes Referral Pathways

A resource toolkit for GPs

- Understand the role and value of working with a Credentialled Diabetes Educator (CDE)
- Improve patient outcomes with a clear referral pathway
- Pathway diagrams for patients to take away

ADEA
Your trusted partner in diabetes care

These diabetes pathways provide guidance for the care of people with diabetes. Diabetes pathways show the milestones on a person's journey from diagnosis through the lifespan of diabetes management, which includes input and advice from a range of diabetes health professionals to ensure the person is supported through self-management education and evidence-based diabetes management principles.

The resources in this kit will help GPs, health professionals and people with diabetes navigate diabetes education and management services from the time of diagnosis, including when to talk to a Credentialled Diabetes Educator (CDE).

A CDE is a health professional who is recognised by the Australian Diabetes Educators Association (ADEA) for their specialist knowledge and professional development in the field of diabetes education, which is vital for teaching patients to successfully self-manage their condition.

Complementing the clinical and health care support provided by GPs, CDEs bring specialised holistic expertise in diabetes care and management, and the ability to tailor advice to the person with diabetes' situation.

Understanding the CDE's role and when to refer to a CDE creates more opportunities to help your patients progress towards diabetes self-management through ongoing education, skills development and reinforcement of positive behaviours at key points in time as their health needs change.

CDEs work closely with people with diabetes to:

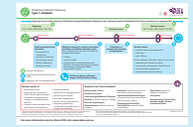
- listen to and understand their priorities, knowledge and needs
- tailor education and clinical advice to their situation, their culture and where they are on their diabetes pathway
- provide in-depth knowledge across all key areas of diabetes care and management
- recommend other specialists and allied health professionals where needed.

Resources provided in this kit:

- Detailed diagrams outlining the pathways for GP information
- Simplified diagrams you can print and give to people with diabetes

GP Resources

Better patient care with diabetes referral pathways


Type 1 diabetes


Type 2 diabetes

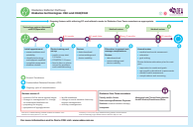

Type 2 diabetes – insulin initiation and stabilisation


Gestational diabetes (GDM)


Pregnancy with pre-existing diabetes from pre-conception to post partum

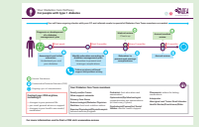

Children and adolescents with type 1 diabetes


Children and adolescents with type 2 diabetes


Diabetes technologies: CSII and CGM/FGM

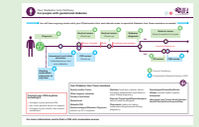
Patient Resources

Your diabetes care pathway - from your GP and CDE


For people with type 1 diabetes


For people with type 2 diabetes


For people with type 2 diabetes – starting insulin


For people with gestational diabetes


For pregnancy with pre-existing diabetes


For children and adolescents with type 1 diabetes


For children and adolescents with type 2 diabetes


Diabetes technologies: insulin pumps and continuous/flash glucose monitoring

Diabetes Referral Pathway
Type 1 diabetes

ADEA
Your trusted partner in diabetes care

Ongoing liaison with referring GP/Endocrinologist/Diabetes Physician and referrals made to Diabetes Care Team members as appropriate

Diagnosis (GP)
*2517-2526, 2620-2635, 725-758

First week

Initial assessment and education: (CDE)
- blood glucose monitoring
- injection technique
- technology options
- NDSS registration
- dietitian consult

First 2 months

Weekly as required: continue education according to diabetes education plan that is responsive to person's needs and management goals: (CDE)
- lifestyle
- mental health
- complications and adjustments to therapy, including starting or changing technology and relevant NDSS registration update

Follow up phone call/email support and problem solving

Medical review (GP)

Every 3 months

Education to prevent and manage complications (CDE)

Medical review (GP)
*2517-2526, 2620-2635, 725-758

12 months

Annual review: (CDE)
- medical and social assessment
- education
- goal setting

Revise diabetes education plan for next year:
- responsive to needs and goals
- age specific educational requirements
- mental health assessment
- complications and screening

GP General Practitioner

CDE Credentialled Diabetes Educator (CDE)

Ongoing cycle of care/education

Review sooner if:

- unresolved issues
- blood glucose or previous HbA1c above agreed targets.
- change in management i.e. change to medication/diet/exercise
- change in social situation that may impact management
- key life transitions
- symptoms of hypoglycaemia
- preparing for surgery
- sick day management
- drivers licence requirements
- pregnancy planning/ contraception needs (refer to pregnancy pathway)

Diabetes Care Team members

Family and/or Carers

Primary Care Nurse

Endocrinologist/Diabetes Physician

Dietitian: medical nutrition therapy

Exercise Physiologist/ Physiotherapist: tailored exercise program

Podiatrist: comprehensive foot education and examination

Optometrist/Ophthalmologist: comprehensive eye examinations (at least every 2 years)

Psychologist/Counsellor/ Social Worker: mental health consultation

Pharmacist: advice for taking medications

Interpreter

Aboriginal and Torres Strait Islander Health Worker/ Practitioner/Elder

- Craig ME, Twigg SM, Donaghue KC, Cheung NW, Cameron FJ, Conn J, Jenkins AJ, Silink M, for the Australian Type 1 Diabetes Guidelines Expert Advisory Group. National evidence-based clinical care guidelines for type 1 diabetes in children, adolescents and adults. Australian Government Department of Health and Ageing, Canberra 2011.
- ADA. Standards of Medical Care in Diabetes 2020. Diabetes Care. 2020:43 (Supplement 1)
- Overland J, Sluis M, Reyna R. Straight to the Point: A guide for adults living with type 1 diabetes. (3rd Ed). St Leonards, NSW. JDRF (Australia) 2019.

* MBS item numbers

Diabetes Referral Pathway
Type 2 diabetes

Your trusted partner in diabetes care

Ongoing liaison with referring GP and referrals made to Diabetes Care Team members as appropriate

Diagnosis/development of a chronic disease management plan (GP)

*2517-2526, 2620-2635, 725-758

2-4 weeks

Assessment and initial education (CDE)

NDSS registration

Medications, lifestyle and complications (CDE)

Medical review (GP)

Investigations as per annual cycle of care as appropriate

3 months

Education to prevent and manage complications (CDE)

Medical review (GP)

Investigations as per annual cycle of care as appropriate

6 months

Review and goal setting (CDE)

9 months

Annual medical review (GP)

*2517-2526, 2620-2635, 725-758

12 months

Annual review (CDE)

Starting medication can occur at any time (CDE)

If insulin is required refer to the Diabetes Referral Pathway: Type 2 diabetes – insulin initiation and stabilisation (CDE)

GP General Practitioner

CDE Credentialled Diabetes Educator (CDE)

Ongoing cycle of care/education

Review sooner if:

- unresolved issues regarding diabetes care
- patient requires blood glucose monitoring (technology options)
- glucose levels or previous HbA1c above target
- change in management i.e. change to medication/diet/exercise
- key life transitions
- change in social situation that may impact management
- symptoms of hypoglycaemia
- preparing for surgery
- sick day management
- driving requirements for those using insulin
- pregnancy planning/contraception needs (refer to pregnancy pathway)

Diabetes Care Team members

Family and/or Carers

Primary Care Nurse

Dietitian: medical nutrition therapy

Exercise Physiologist/ Physiotherapist: tailored exercise program

Podiatrist: comprehensive foot education and examination

Endocrinologist/Diabetes Physician: referral when patient not responding to therapy

Optometrist/Ophthalmologist: comprehensive eye examinations (at least every 2 years)

Psychologist/Counsellor/ Social Worker: mental health consultation

Pharmacist: advice for taking medications

Interpreter

Aboriginal and Torres Strait Islander Health Worker/ Practitioner/Elder

Group education: if appropriate

· RACGP (2020). Management of type 2 diabetes: A handbook for general practice. East Melbourne, Australia, The Royal Australian College of General Practitioners.

* MBS item numbers

Diabetes Referral Pathway
Type 2 diabetes – insulin initiation and stabilisation

Your trusted partner in diabetes care

Ongoing liaison with referring GP and referrals made to Diabetes Care Team members as appropriate

Insulin prescribed (GP)

Initial appointment: (CDE)
- medical and social assessment
- blood glucose monitoring
- injection technique
- education, hypo management
- goal setting
- emotional well-being and support
- medications
- lifestyle
- follow up plan

Dose adjustment (CDE)

Advice and support as needed (telehealth options)

Unresolved issues, 1-2 weeks:
- further assessment & education
- goal setting
- follow up plan

2-4 weeks

2-4 week review: (CDE)
- BGL patterns, SMBG technique
- injection technique
- further education
- goal setting
- follow up plan

Insulin initiation follow up (GP)

3 months

Review: (CDE)
- BGL patterns, SMBG technique
- injection technique
- medications, lifestyle
- further education
- goal setting
- follow up plan

Medical review every 3 months (GP)

6 months

Education review every 3 months: (CDE)
- BGL patterns, SMBG technique
- injection technique
- medication, lifestyle
- further education
- goal setting
- follow up plan

9 months

12 months

Annual review (CDE)
- medical and social assessment
- education
- goal setting
- follow up plan

Follow up phone call/email support and problem solving

GP General Practitioner

CDE Credentialled Diabetes Educator (CDE)

Ongoing cycle of care/ education

Review sooner if:
- previous Hb1Ac above agreed target
- change in management i.e. change to medication/diet/ exercise
- preparing for surgery
- symptoms of hypoglycaemia
- change in social situation that may impact management
- sick day management

Diabetes Care Team members

Endocrinologist/Diabetes Physician

Dietitian: medical nutrition therapy

Primary Care Nurse

Interpreter

Aboriginal and Torres Strait Islander Health Worker/ Practitioner/Elder

Pharmacist

Psychologist/Counsellor/ Social Worker: mental health consultation

Group education: if appropriate

- ADEA (2017). Clinical Guiding Principles for Subcutaneous Injection Technique: technical guidelines Canberra, Australian Diabetes Educators Association.
- RACGP (2020). Management of type 2 diabetes: A handbook for general practice. East Melbourne, Australia, The Royal Australian College of General Practitioners.
- Stapleton, N. (2016). RACGP General Practice Management of Type 2 Diabetes. Diabetes.

Diabetes Referral Pathway
Gestational diabetes (GDM)

Your trusted partner in diabetes care

Ongoing liaison with referring GP/antenatal clinic/Physician

Diagnosis (GP)

Assessment and initial education (CDE)
- blood glucose monitoring
- NDSS registration
- dietitian consult

Medical review (GP)

CDE review/Diabetes Team review (CDE)
- glucose monitoring
- stabilisation of medications as required
- lifestyle, weight management and well-being checks
- birth plan and post birth management

Every 2 weeks

Medical review (GP)

Repeat tests, including Oral Glucose Tolerance Test

Birth

6 weeks post-partum

Diabetes diagnosis (GP)

No

Post-birth follow up as indicated

Medical review (GP)

Every 6 months to 2 years (consider IFG.IGT) *701-707

Yes

GP review as per appropriate pathway (GP)

CDE review as required as per appropriate pathway (CDE)

Starting medication can occur at any time (CDE)

If commencing insulin initial appointment: (CDE)
- injection technique
- blood glucose monitoring
- technology options
- NDSS registration update

Dose adjustment (CDE)

Advice and support (telehealth options)

GP General Practitioner

CDE Credentialled Diabetes Educator (CDE)

Review sooner if:

- unresolved issues regarding diabetes care
- glucose levels are above agreed targets
- symptoms of hypoglycaemia
- preparing for surgery
- change in management i.e. change to medication/diet/exercise
- change in social situation that may impact management
- sick day management

Diabetes Care Team members

Family and/or Carers

Primary Care Nurse

Obstetrician

Midwife CDE

Endocrinologist/Diabetes Physician: referral when patient not responding to therapy

Dietitian: medical nutrition therapy

Exercise Physiologist/ Physiotherapist: tailored exercise program

Pharmacist: advice for taking medications/supplements during pregnancy

Psychologist/Counsellor /Social Worker: mental health consultation

Interpreter

Aboriginal and Torres Strait Islander Health Worker/ Practitioner/Elder

Group education: if appropriate

· Nankervis, A., et al. (2014). ADIPS consensus guidelines for the testing and diagnosis of hyperglycaemia in pregnancy in Australia and New Zealand. Australasian Diabetes in Pregnancy Society: 1-8.

* MBS item numbers

Diabetes Referral Pathway

Pregnancy with pre-existing diabetes from pre-conception to post partum

Your trusted partner in diabetes care

Ongoing liaison with referring GP/Endocrinologist and Obstetric team

Planning for pregnancy (GP)

Metabolic stability is recommended for at least 3 months prior to conception

Pre-Conception Planning

Conception

Conception to week 32: fortnightly review

Medical review (GP)

Repeat investigations

32–40 weeks: weekly review

Birth

Medical review (GP)

Post Partum

Initial appointment (CDE)

- potential changes in diabetes management (technology options)
- NDSS registration review

Review blood glucose monitoring: (CDE)

- review blood glucose
- review NDSS registration and lifestyle aspects

Review changes to medication and technology settings (CDE)

- refer to type 2 insulin initiation or diabetes technologies pathways as required

Review diabetes management (CDE)

Ongoing assessment of SMBG and insulin requirements: (CDE)

- prepare for delivery
- assess injection/pump sites and adjust administration as needed
- assess issues, problem solving and goal setting

Review diabetes management: (CDE)

- review blood glucose medications
- breastfeeding
- weight management
- return to new routine while managing diabetes

GP General Practitioner

CDE Credentialled Diabetes Educator (CDE)

Review sooner if:

- unresolved issues regarding diabetes care
- glucose levels or HbA1c above agreed targets
- change in management i.e. change to medication/diet/exercise/technology
- symptoms of hypoglycaemia
- change in social situation that may impact management
- preparing for surgery
- sick day management

Diabetes Care Team members

Family and/or Carers

Obstetrician

Midwife/CDE

Endocrinologist/Diabetes Physician

Dietitian: medical nutrition therapy and foods to avoid during pregnancy

Exercise Physiologist/ Physiotherapist: tailored exercise program

Primary Care Nurse

Podiatrist: comprehensive foot examination

Optometrist/Opthalmologist: comprehensive eye examinations (at least every 2 years)

Pharmacist: advice for taking medications during pregnancy

Psychologist/Counsellor/ Social Worker: mental health consultation

Interpreter

Aboriginal and Torres Strait Islander Health Worker/ Practitioner/Elder

- NICE (2020). Diabetes in Pregnancy Overview United Kingdom, National Institute for Health and Care Excellence (NICE).
- Webber, J., et al. (2015). Diabetes in pregnancy: management of diabetes and its complications from preconception to the postnatal period (NG3). British Journal of Diabetes 15(3): 107-111.
- Nankervis, A., et al. (2014). ADIPS consensus guidelines for the testing and diagnosis of hyperglycaemia in pregnancy in Australia and New Zealand. Australasian Diabetes in Pregnancy Society: 1-8.

Diabetes Referral Pathway
Children and adolescents with type 1 diabetes

ADEA
Your trusted partner in diabetes care

Ongoing liaison with referring GP/Endocrinologist/Diabetes Physician and referrals made to Diabetes Care Team members as appropriate

Diagnosis *2517-2526, 2620-2635, 725-758 (GP)

Referral to paediatric diabetes team

First week

Initial assessment and education: (CDE)

- blood glucose monitoring
- injection technique
- technology options
- NDSS registration
- dietitian consult
- family-centric age-appropriate education

First 2 months

Weekly as required: continue education according to diabetes education plan that is responsive to person's needs and management goals: (CDE)

- lifestyle
- mental health
- complications and adjustments to therapy, including starting or changing technology and relevant NDSS registration update
- School/carers education as required

Follow up phone call/email support and problem solving

Medical review (GP)

Every 3 months

Education to prevent and manage complications (CDE)

Medical review (GP)

*2517-2526, 2620-2635, 725-758

12 months

Annual review: (CDE)

- medical and social assessment
- education
- goal setting

Revise diabetes education plan for next year:

- responsive to needs and goals
- age specific educational requirements
- mental health assessment
- complications and screening
- ongoing liaison with family/carers and school

GP General Practitioner

CDE Credentialled Diabetes Educator (CDE)

Ongoing cycle of care/education

Review sooner if:

- unresolved issues
- blood glucose or previous HbA1c above agreed targets.
- change in management i.e. change to medication/diet/exercise
- change in social situation that may impact management
- key life transitions
- symptoms of hypoglycaemia
- preparing for surgery
- sick day management
- drivers licence requirements
- pregnancy planning/ contraception needs (refer to pregnancy pathway)

Diabetes Care Team members

Family and/or Carers

Primary Care Nurse

Endocrinologist/Diabetes Physician

Dietitian: medical nutrition therapy

Podiatrist: comprehensive foot education and examination

Exercise Physiologist/ Physiotherapist: tailored exercise program

Optometrist/Ophthalmologist: comprehensive eye examinations (at least every 2 years)

Psychologist/Counsellor/ Social Worker: mental health consultation

Pharmacist: advice for taking medications

Interpreter

Aboriginal and Torres Strait Islander Health Worker/ Practitioner/Elder

Teaching and school staff /school nurse

- Craig ME, Twigg SM, Donaghue KC, Cheung NW, Cameron FJ, Conn J, Jenkins AJ, Silink M, for the Australian Type 1 Diabetes Guidelines Expert Advisory Group. National evidence-based clinical care guidelines for type 1 diabetes in children, adolescents and adults. Australian Government Department of Health and Ageing, Canberra 2011.
- ADA. Standards of Medical Care in Diabetes 2020. Diabetes Care. 2020:43 (Supplement 1)
- Overland J, Sluis M, Reyna R. Straight to the Point: A guide for adults living with type 1 diabetes. (3rd Ed). St Leonards, NSW. JDRF (Australia) 2019.

* MBS item numbers

Diabetes Referral Pathway
Children and adolescents with type 2 diabetes

Your trusted partner in diabetes care

Ongoing liaison with referring GP and referrals made to Diabetes Care Team members as appropriate

Diagnosis/development of a chronic disease management plan *2517-2526, 2620-2635, 725-758 (GP)

Referral to paediatric diabetes team

Medical review (GP)

Investigations as per annual cycle of care as appropriate

Medical review (GP)

Investigations as per annual cycle of care as appropriate

Annual medical review (GP)

*2517-2526, 2620-2635, 725-758

2-4 weeks | 3 months | 6 months | 9 months | 12 months

Assessment and initial education (CDE)
- NDSS registration
- family-centric age-appropriate education
- dietitian consult

Medications, lifestyle and complications (CDE)

Education to prevent and manage complications (CDE)

Review and goal setting (CDE)

Annual review (CDE)

Starting medication can occur at any time (CDE)

If insulin is required refer to the Diabetes Referral Pathway: Type 2 diabetes – insulin initiation and stabilisation (CDE)

GP General Practitioner

CDE Credentialled Diabetes Educator (CDE)

Ongoing cycle of care/education

Review sooner if:

- unresolved issues regarding diabetes care
- patient requires blood glucose monitoring (technology options)
- glucose levels or previous HbA1c above target
- change in management i.e. change to medication/diet/exercise
- key life transitions
- change in social situation that may impact management
- symptoms of hypoglycaemia
- preparing for surgery
- sick day management
- driving requirements for those using insulin
- pregnancy planning/contraception needs (refer to pregnancy pathway)

Diabetes Care Team members

Family and/or Carers

Primary Care Nurse

Dietitian: medical nutrition therapy

Endocrinologist/Diabetes Physician: referral required when patient not responding to therapy

Interpreter

Exercise Physiologist/ Physiotherapist: tailored exercise program

Podiatrist: comprehensive foot education and examination

Optometrist/Ophthalmologist: comprehensive eye examinations (at least every 2 years)

Pharmacist: advice for taking medications

Psychologist/Counsellor/ Social Worker: mental health consultation

Aboriginal and Torres Strait Islander Health Worker/ Practitioner/Elder

Teaching and school staff /school nurse

· RACGP (2020). Management of type 2 diabetes: A handbook for general practice. East Melbourne, Australia, The Royal Australian College of General Practitioners.

* MBS item numbers

Diabetes Referral Pathway
Diabetes technologies: CSII and CGM/FGM

Your trusted partner in diabetes care

Ongoing liaison with referring GP and referrals made to Diabetes Care Team members as appropriate

Technology options discussed with GP/Specialist (GP)

Initial appointment: (CDE)
- assess readiness and suitability
- identify technology and support required
- complete paperwork
- dietitian consult

2-4 weeks

Device training and set up: (CDE)
- insulin pump start 2-6 hours
- CGM/FGM 1-2 hours
- face-to-face or phone review for questions and troubleshooting

1 week later

Review: (CDE)
- data download
- review settings and device usability

Medical review (GP)

Every 3 months

Education to prevent and manage complications (CDE)

Review:
- data download
- review settings and device usability

Medical review (GP)

12 months

Annual review: (CDE)
- medical and social assessment
- education
- goal setting

Revise diabetes education plan for next year:
- responsive to needs and goals
- age specific educational requirements
- mental health assessment
- complications and screening

GP General Practitioner

CDE Credentialled Diabetes Educator (CDE)

Ongoing cycle of care/education

Review sooner if:

- previous Hb1Ac above agreed target
- change in management i.e. change to medication/diet/exercise
- preparing for surgery
- symptoms of hypoglycaemia
- key life transitions
- change in social situation that may impact management
- sick day management

Diabetes Care Team members

Family and/or Carers

Endocrinologist/Diabetes Physician

Dietitian: medical nutrition therapy

Interpreter

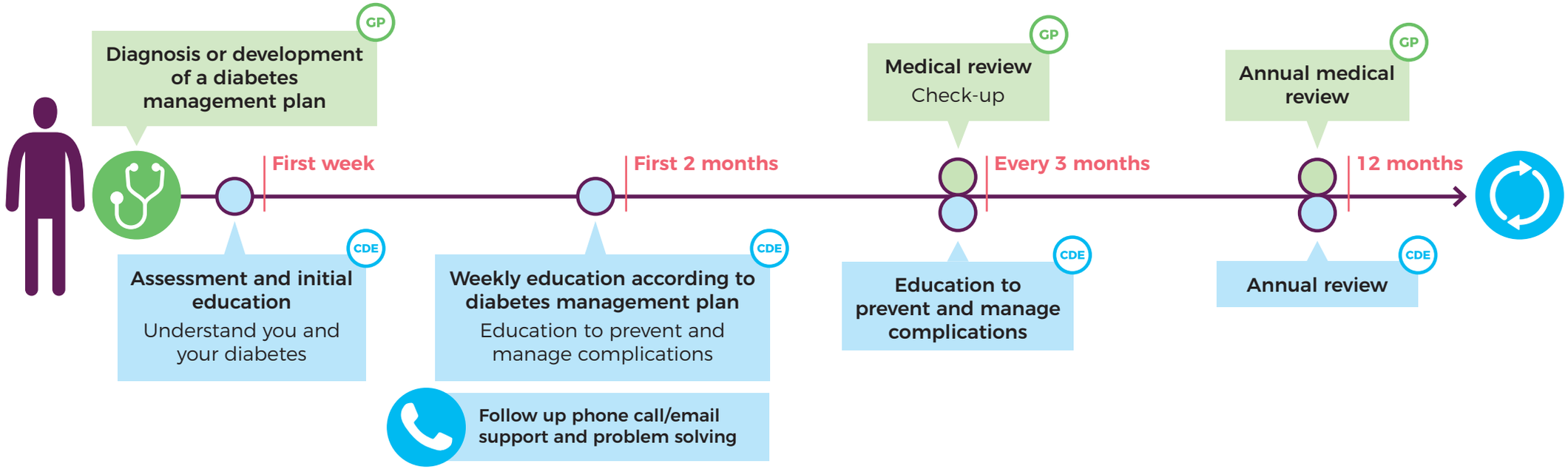
Aboriginal and Torres Strait Islander Health Worker/Practitioner/Elder

- ADA (2019). 7. Diabetes technology: standards of medical care in diabetes—2019. Diabetes Care 42(Supplement 1): S71-S80.
- Choudhary, P., et al. (2019). A Type 1 diabetes technology pathway: consensus statement for the use of technology in Type 1 diabetes. Diabetic Medicine 36(5): 531-538.

Your Diabetes Care Pathway
For people with type 1 diabetes

ADEA
Your trusted partner in diabetes care

You will have ongoing checks with your GP and referrals made to specialist Diabetes Care Team members as needed



GP General Practitioner

CDE Credentialled Diabetes Educator (CDE)

Ongoing cycle of care/education

Contact your CDE anytime, including if:

- changes in your personal life
- you need general advice or support
- changes in your health care needs/ medication

Your Diabetes Care Team members

Family and/or Carers

Other support networks

Primary Care Nurse

Endocrinologist/Diabetes Physician

Dietitian: food and nutrition advice

Exercise Physiologist/Physiotherapist: tailored exercise program

Podiatrist: foot education and examination

Optometrist/Ophthalmologist: comprehensive eye examinations (at least every 2 years)

Psychologist/Counsellor/ Social Worker: mental health support

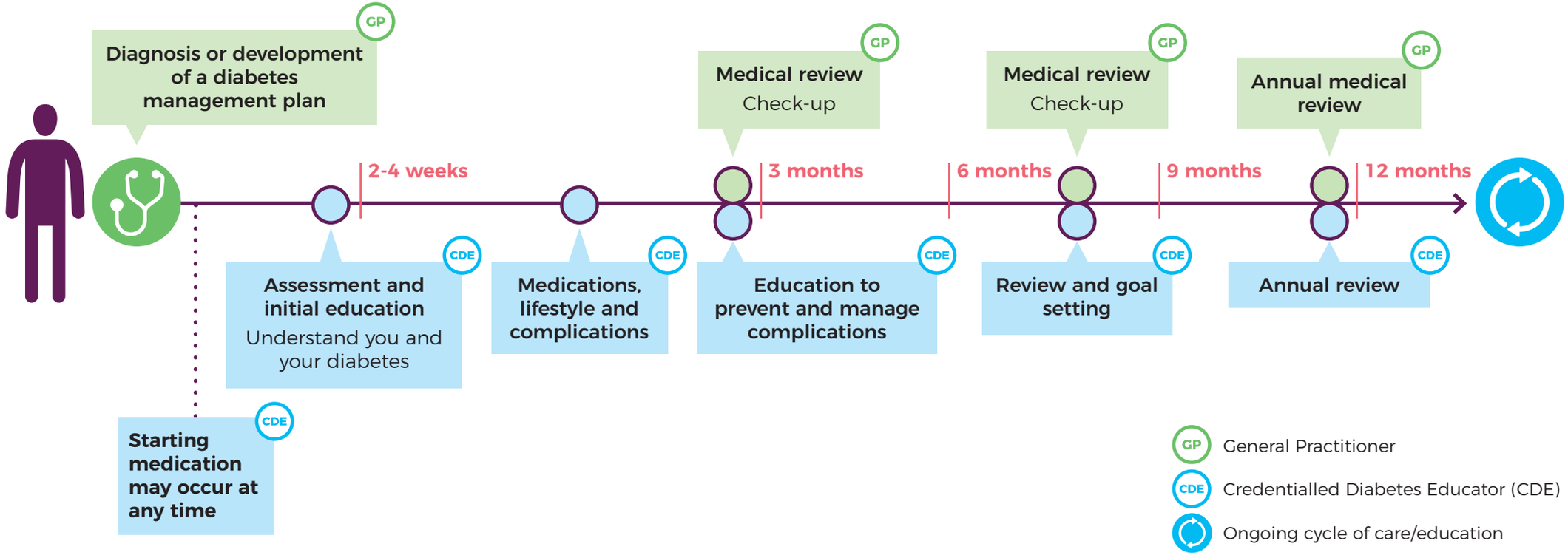
Pharmacist: advice for taking medications

Interpreter

Aboriginal and Torres Strait Islander Health Worker/Practitioner/Elder

Your Diabetes Care Pathway
For people with type 2 diabetes

You will have ongoing checks with your GP and referrals made to specialist Diabetes Care Team members as needed



Contact your CDE anytime, including if:

- changes in your personal life
- you need general advice or support
- changes in your health care needs/ medications

Your Diabetes Care Team members

Family and/or Carers

Other support networks

Primary Care Nurse

Dietitian: food and nutrition advice

Exercise Physiologist/Physiotherapist: tailored exercise program

Endocrinologist/Diabetes Physician: referral by GP if required

Podiatrist: foot education and examination

Optometrist/Ophthalmologist: eye examinations (at least every 2 years)

Psychologist/Counsellor/ Social Worker: mental health support

Pharmacist: advice for taking medications

Interpreter

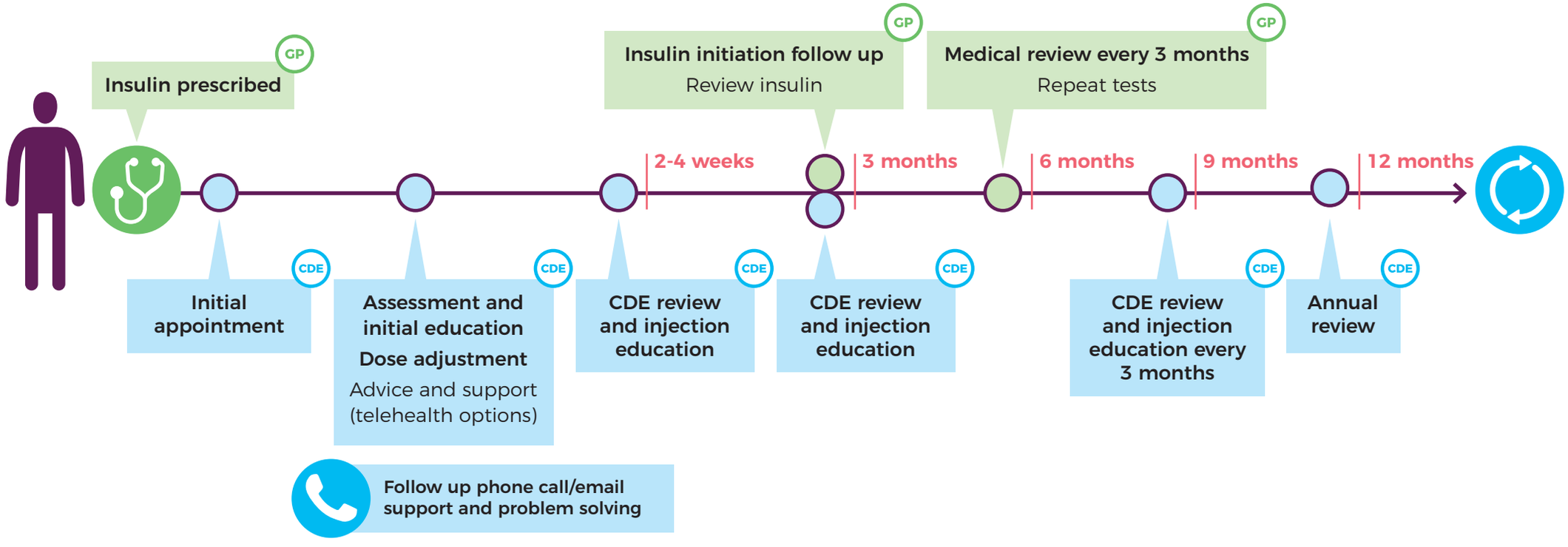
Aboriginal and Torres Strait Islander Health Worker/Practitioner/Elder

Your Diabetes Care Pathway

For people with type 2 diabetes – starting insulin

Your trusted partner in diabetes care

You will have ongoing checks with your GP and referrals made to specialist Diabetes Care Team members as needed



GP General Practitioner

CDE Credentialled Diabetes Educator (CDE)

Ongoing cycle of care/education

Contact your CDE anytime, including if:

- changes in your personal life
- you need general advice or support
- changes in your health care needs/ medication

Your Diabetes Care Team members

Family and/or Carers

Other support networks

Endocrinologist/Diabetes Physician

Dietitian: food and nutrition advice

Primary Care Nurse

Interpreter

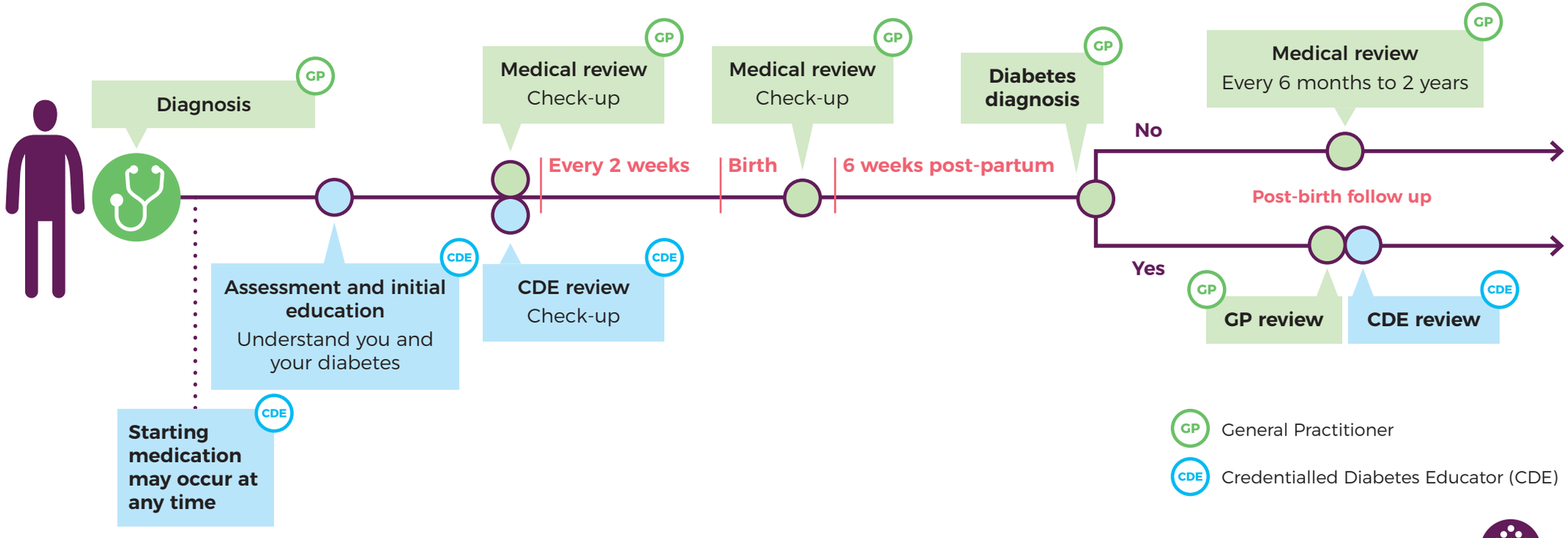
Aboriginal and Torres Strait Islander Health Worker/ Practitioner/Elder

Pharmacist: advice for taking medications

Psychologist/Counsellor/Social Worker: mental health support

Your Diabetes Care Pathway
For people with gestational diabetes

You will have ongoing checks with your GP/antenatal clinic and referrals made to specialist Diabetes Care Team members as needed



Contact your CDE anytime, including if:

- changes in your personal life
- you need general advice or support
- changes in your health care needs/ medication

Your Diabetes Care Team members

Family and/or Carers

Other support networks

Primary Care Nurse

Obstetrician

Midwife CDE

Endocrinologist/Diabetes Physician: referral by GP if required

Dietitian: food and nutrition advice including supplements and foods to avoid during pregnancy

Exercise Physiologist/Physiotherapist: tailored exercise program

Pharmacist: advice for taking medications/supplements during pregnancy

Psychologist/Counsellor/Social Worker: mental health support

Interpreter

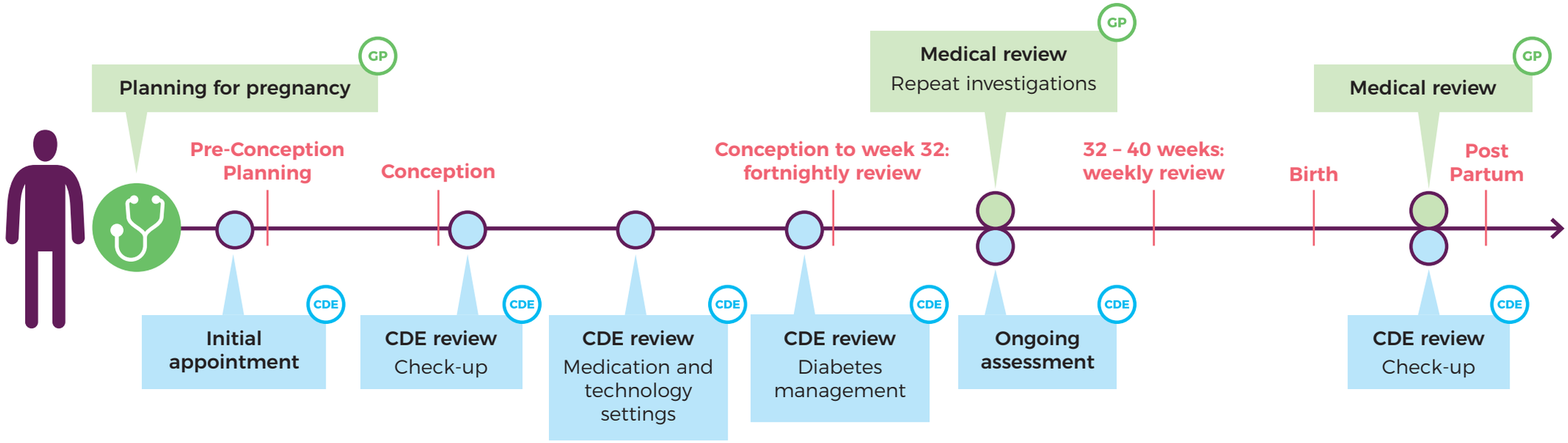
Aboriginal and Torres Strait Islander Health Worker/Practitioner/Elder

Your Diabetes Care Pathway

For pregnancy with pre-existing diabetes

ADEA
Your trusted partner in diabetes care

You will have ongoing checks with your GP / Endocrinologist and Obstetric team



GP General Practitioner

CDE Credentialled Diabetes Educator (CDE)

Contact your CDE anytime, including if:

- changes in your personal life
- you need general advice or support
- changes in your health care needs/ medication

Your Diabetes Care Team members

Family and/or Carers

Other support networks

Obstetrician

Midwife/CDE

Dietitian: food and nutrition advice including supplements and foods to avoid during pregnancy

Exercise Physiologist/Physiotherapist: tailored exercise program

Primary Care Nurse

Podiatrist: foot education and examination

Optometrist/Opthalmologist: comprehensive eye examinations (at least every 2 years)

Pharmacist: advice for taking medications/ supplements during pregnancy

Psychologist/Counsellor/Social Worker: mental health support

Interpreter

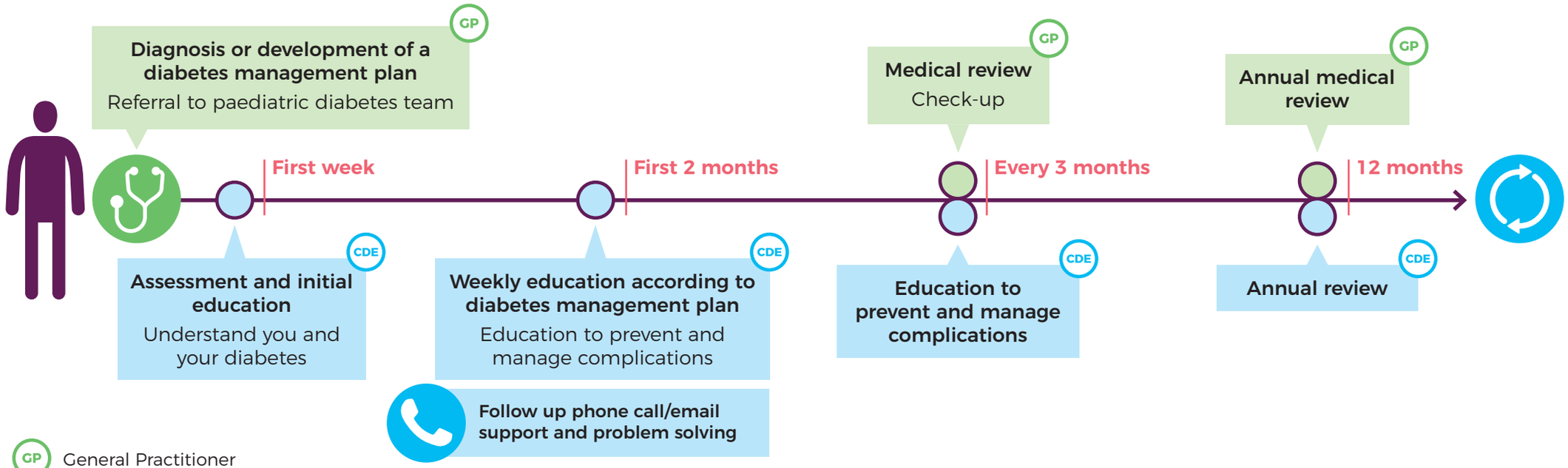
Aboriginal and Torres Strait Islander Health Worker/Practitioner/Elder

Your Diabetes Care Pathway

For children and adolescents with type 1 diabetes

Your trusted partner in diabetes care

You will have ongoing checks with your GP/Endocrinologist/Diabetes Physician and referrals made to specialist Diabetes Care Team members as needed



GP General Practitioner

CDE Credentialled Diabetes Educator (CDE)

Ongoing education may be required

Contact your CDE anytime, including if:

- changes in your personal life
- you need general advice or support
- changes in your health care needs/ medication

Your Diabetes Care Team members

Family and/or Carers

Other support networks

Primary Care Nurse

Endocrinologist/Diabetes Physician

Dietitian: food and nutrition advice

Exercise Physiologist/Physiotherapist: tailored exercise program

Podiatrist: foot education and examination

Optometrist/Ophthalmologist: eye examinations (at least every 2 years)

Psychologist/Counsellor/ Social Worker: mental health support

Pharmacist: advice for taking medications

Interpreter

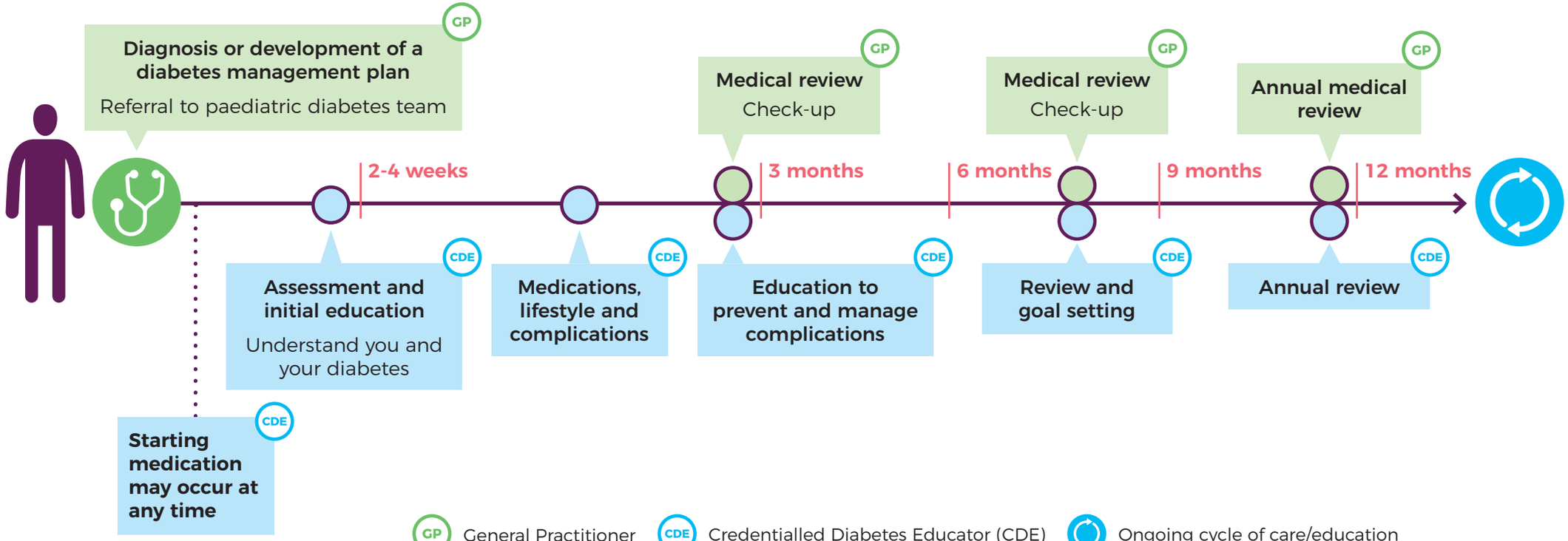
Aboriginal and Torres Strait Islander Health Worker/Practitioner/Elder

Teaching and school staff /school nurse

Your Diabetes Care Pathway
For children and adolescents with type 2 diabetes

ADEA
Your trusted partner in diabetes care

You will have ongoing checks with your GP and referrals made to specialist Diabetes Care Team members as needed



GP General Practitioner

CDE Credentialled Diabetes Educator (CDE)

Ongoing cycle of care/education

Your Diabetes Care Team members

Family and/or Carers

Other support networks

Primary Care Nurse

Dietitian: food and nutrition advice

Exercise Physiologist/Physiotherapist: tailored exercise program

Endocrinologist/Diabetes Physician: referral by GP if required

Podiatrist: foot education and examination

Optometrist/Ophthalmologist: eye examinations (at least every 2 years)

Psychologist/Counsellor/ Social Worker: mental health support

Pharmacist: advice for taking medications

Interpreter

Aboriginal and Torres Strait Islander Health Worker/Practitioner/Elder

Teaching and school staff /school nurse

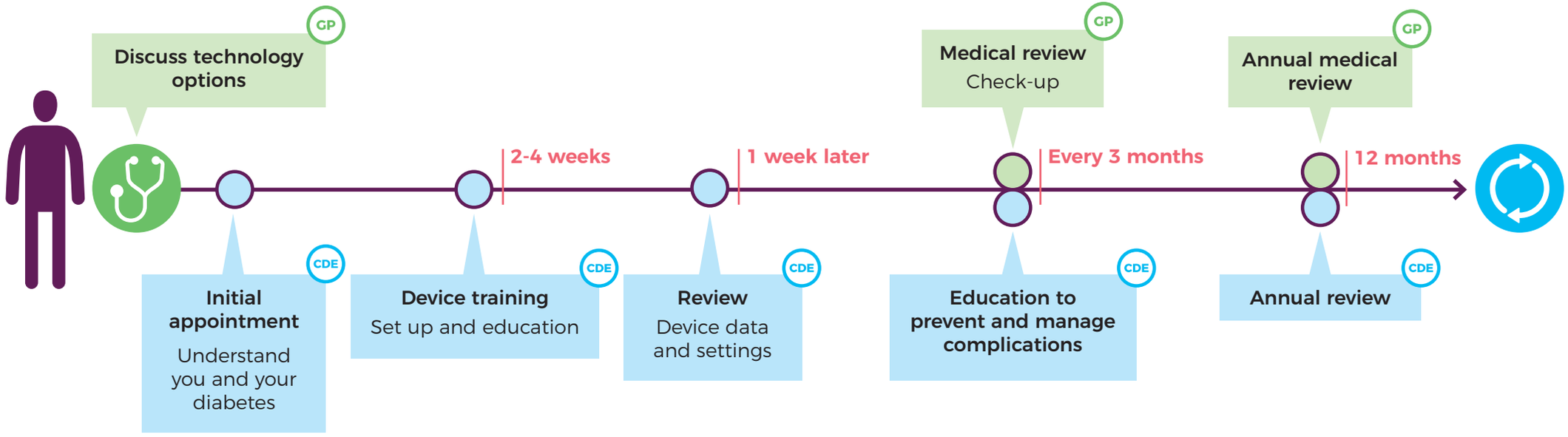
Contact your CDE anytime, including if:

- changes in your personal life
- you need general advice or support
- changes in your health care needs/ medication

Your Diabetes Care Pathway

Diabetes Technologies: Insulin pumps and continuous/flash glucose monitoring

You will have ongoing checks with your GP and referrals made to specialist Diabetes Care Team members as needed



GP General Practitioner

CDE Credentialled Diabetes Educator (CDE)

Ongoing cycle of care/education

Contact your CDE anytime, including if:

- changes in your personal life
- you need general advice or support
- changes in your health care needs/ medication

Your Diabetes Care Team members

Family and/or Carers

Other support networks

Endocrinologist (Adult or Paediatric)

Dietitian: food and nutrition advice

Interpreter

Aboriginal and Torres Strait Islander Health Worker/Practitioner/Elder