REQUEST FOR CONSULTATION

GOLD COAST HOSPITAL AND HEALTH SERVICE

**DIABETES MELLITUS SERVICE CLINIC**

**CHRONIC DISEASE WELLNESS PROGRAM**

Specialising in Community based multidisciplinary care for Patients with complex care needs.

Supporting Team Care Arrangements (without utilising Medicare items)

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| **SEND TO**: Dr Harish VenugopalCentral Intake UnitFax: 1300 668 536 **OR** Phone: 1300 668 936**Secure transmission service via Medical Objects or****Healthlink to****QHEALTH,GOLD COAST HEALTH Adult Community Health Central Intake Unit** | **FROM** **Doctors Name:** **Practice Name:****Practice Address:****Phone:** **Fax:** **Email:** **Provider Number:**  |

**This service is for patients 18 years and older with a diagnosis of Diabetes mellitus or Pre-Diabetes.**

Dear Dr Venugopal

**SECTION 1 Patient details**

**Patient Full Name:**

**DOB:**

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| **Gender:** **Address:** **Home Ph**: **Mobile Ph:** **Medicare Number\*:** (\*Medicare ineligible patients will incur a consultation fee) | **Next of Kin/Alternative Contact:** **Next of Kin/Alternative Contact Ph:** **Does patient identify as Aboriginal and/or Torres Strait** **Islander:** **Interpreter required:** **If yes, specify language:**  |
| **SECTION 2 Reason for referral and additional clinical information** |

What is the reason for this referral:

Please provide provisional diagnosis (if available):

Please include any symptoms and date of onset (if known):

**Paste or type relevant history, clinical examination findings and treatment to date if required**

**SECTION 3 Mandatory clinical information**

Has a Team Care Arrangement been completed:

If yes, specify and attach GPMP/TCA

When was the diagnosis made, specify date:

Does patient have comorbidities restricting exercise:

If yes please specify comorbidities:

Has patient used 8 group-based exercise sessions through GPMP:

The Diabetes Service encourages use of the eight group-based exercise sessions available through the Medicare item number Type 2 Diabetes Group services (completion of a GPMP item number 721 is a requirement to access this service). The local provider list is available as a separate document.

**SECTION 4 Investigations**

Please indicate whether the following pre-requisite investigations have been undertaken in order for this referral to be processed and attach the results.

**HbA1c:**

**Fasting blood glucose/OGTT:**

**Full lipid:**

**A random urine albumin:creatinine ratio:**

**FBC:**

**E/LFT:**

In addition, please also attach investigation results you consider to be relevant. An optometrist report is particularly useful.

**SECTION 5 Social factors and impact on the patient**

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| Consider the impact on employment/education; activities of daily life; ability to care for others; personal safety/frailty;other factors. **Please paste or type relevant information.** |

**SECTION 6 Medical history including co-morbidities and previous surgical interventions**

**Alcohol Status/History:**

**Smoking Status/History:**

**Medical History:**

**Comorbidities:**

**Previous Procedures:**

**Allergies/Adverse Reactions:**

**Current prescribed medications:**

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| **SMOs/VMOs in the Specialist Service** |

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| Dr Harish Venugopal | Professor Nick Buckmaster | Dr Nadarajah Mugunthan |