



Moorditj Djena Referral Form - Podiatry, Dietetics & Diabetes Education

*** Eligible clients must be of Aboriginal/Torres Strait Islander descent and 18+Years of Age ***

PATIENT DETAILS		REFERRER																																																					
Surname: _____ First: _____		Name																																																					
Address: _____		Organisation																																																					
Post Code: _____	Phone: _____	Address																																																					
URMN: _____	DOB: ____ / ____ / ____	Post Code	Phone																																																				
<input type="checkbox"/> Male <input type="checkbox"/> Female	Country of Birth: _____	GP DETAILS (if different to above)																																																					
Aboriginal <input type="checkbox"/> Yes TSI <input type="checkbox"/> Yes		Name: _____																																																					
Interpreter Required <input type="checkbox"/> Yes <input type="checkbox"/> No		GP Practice: _____																																																					
Visual Impairment <input type="checkbox"/> Yes <input type="checkbox"/> No		Address: _____																																																					
Hearing Impairment <input type="checkbox"/> Yes <input type="checkbox"/> No		Post Code: _____	Phone: _____																																																				
Alternative Contact Name: _____		Fax: _____																																																					
Alternative Contact Phone: _____																																																							
REFERRAL TYPE		MEDICAL CONDITIONS																																																					
<input type="checkbox"/> Podiatry <input type="checkbox"/> Footwear referral <input type="checkbox"/> Ulcer Care <input type="checkbox"/> Nail Surgery		<input type="checkbox"/> Heart disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Peripheral neuropathy <input type="checkbox"/> Peripheral arterial disease <input type="checkbox"/> Diabetes Type _____ Year of Diagnosis _____ <input type="checkbox"/> Kidney disease Stage _____ <input type="checkbox"/> Dialysis Type: _____ Other: _____																																																					
<input type="checkbox"/> Diabetes Educator <input type="checkbox"/> HbA1c ≥ 8 or $>$ or 64 mmol/mol <input type="checkbox"/> Insulin Initiation and/or Stabilisation <input type="checkbox"/> Blood glucose monitoring		Current Medications <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please attached current list <input type="checkbox"/> Attached																																																					
<input type="checkbox"/> Dietitian <input type="checkbox"/> Diabetes <input type="checkbox"/> Improved blood lipids / blood pressure <input type="checkbox"/> Kidney disease / dialysis Other: _____		Allergies/ Alerts: _____																																																					
Additional Information		<table border="1"> <thead> <tr> <th colspan="4">PATHOLOGY RESULTS</th> </tr> <tr> <th>Copies attached</th> <th><input type="checkbox"/> Yes</th> <th><input type="checkbox"/> No</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td>Blood Pressure</td> <td></td> <td></td> <td>mmHG</td> </tr> <tr> <td>HbA1c</td> <td></td> <td></td> <td>% / mmol/mol</td> </tr> <tr> <td>Lipids</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Total-C</td> <td>_____</td> <td></td> <td>mmol/L</td> </tr> <tr> <td>Trig</td> <td>_____</td> <td></td> <td></td> </tr> <tr> <td>HDL-C</td> <td>_____</td> <td></td> <td></td> </tr> <tr> <td>LDL-C</td> <td>_____</td> <td></td> <td></td> </tr> <tr> <td>Microalbuminuria</td> <td></td> <td></td> <td>Mg/L</td> </tr> <tr> <td>Alb/Creat Ratio (ACR)</td> <td></td> <td></td> <td>Mg/mmol/L</td> </tr> <tr> <td>eGFR</td> <td></td> <td></td> <td>mL/min</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		PATHOLOGY RESULTS				Copies attached	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date	Blood Pressure			mmHG	HbA1c			% / mmol/mol	Lipids				Total-C	_____		mmol/L	Trig	_____			HDL-C	_____			LDL-C	_____			Microalbuminuria			Mg/L	Alb/Creat Ratio (ACR)			Mg/mmol/L	eGFR			mL/min				
PATHOLOGY RESULTS																																																							
Copies attached	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date																																																				
Blood Pressure			mmHG																																																				
HbA1c			% / mmol/mol																																																				
Lipids																																																							
Total-C	_____		mmol/L																																																				
Trig	_____																																																						
HDL-C	_____																																																						
LDL-C	_____																																																						
Microalbuminuria			Mg/L																																																				
Alb/Creat Ratio (ACR)			Mg/mmol/L																																																				
eGFR			mL/min																																																				
Need Transport <input type="checkbox"/> Yes <input type="checkbox"/> No																																																							
* Note: We do not require a GPMP/TCA to accept patient referrals.																																																							
Name: _____		Signature: _____	Date: ____ / ____ / ____																																																				

Moorditj Djena - East Metropolitan Health Service
 Telephone: (08) 9278 9922 Fax: (08) 92501419
 Email referral to moorditjdjena@health.wa.gov.au

