Case conferencing wishes to assist primary care with the management of ***adult non-pregnant patients with diabetes****.*

Case Conferences can be scheduled by sending referrals to[SWSLHD-CampbelltownIDC@health.nsw.gov.au](mailto:SWSLHD-CampbelltownIDC@health.nsw.gov.au)

or **Fax: (02) 4634 3215** or by contacting DOMTRU administration on **(02) 4634 3192**.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referring Doctor** | | | | | | | | | | | | | | | | | |
| Doctor's Name: | | | |  | | | | | | Phone: | | | |  | | | |
| Address: | |  | | | | | | | | | | | | | | | |
| Email: | |  | | | | | | | | Fax: | | | |  | | | |
| **Patient Information** | | | | | | | | | | | | | | | | | |
| Family name: | | |  | | | | | | | Given Names: |  | | | | | | |
| Sex: |  | | | | | | | | | Date of Birth: |  | | | | | | |
| Phone (H): | | |  | | | | | | | Phone (W): |  | | | | | | |
| Phone (M): | | |  | | | | | | | Aboriginal and Torres Strait Islander Status: | | | | | | |  |
| Medicare Number: | | | | |  | | | | | Medicare Expiry date: | | | | |  | | |
| **PATIENT CONSENT** | | | | | **Obtained**  **Verbal**  **Written** | | | | | | | | | | | | |
| **Required Information** | | | | | | | | | | | | | | | | | |
| Type of diabetes: | | | |  | | | Height: |  | | | | | | Weight: | |  | |
| Most recent HbA1c result: | | | | | | |  | | | | | | | | | | |
| [Diabetes medication (please include doses):](#BPSFIELD|X|10|||) | | | | | | |  | | | | | | | | | | |
| Cardiovascular risk category: | | | | | | | Low | | Medium | | | | High | | | | |
| Lipid therapy: | | | | | | | Yes  No | | If yes details: | | | | | | | | |
| Blood pressure medication: | | | | | | | Yes  No | | If yes details: | | | | | | | | |
| Significant comorbidities: | | | | | | | Yes  No | | If yes details: | | | | | | | | |
| Episodes of hypoglycaemia: | | | | | | | Yes  No | | If yes details: | | | | | | | | |
| Self-monitored BSL: | | | | | | | Yes  No | | If yes details: | | | | | | | | |
| End organ damage: | | | | | | | Yes  No | | If yes details: | | | | | | | | |
| Individualised HbA1c target: | | | | | | |  | | | | | | | | | | |
| Carer assisting in management: | | | | | | |  | | | | | | | | | | |
| Agreed coordinating health practitioner: | | | | | | |  | | | | | | | | | | |
| **Please attached the following test results if available and patient summary:** | | | | | | | | | | | | | | | | | |
| Fasting BSL  T Chol | | | | | | Triglycerides  HDL-C | | LDL-C  eGFR | | | | Albumin:Creatinine Ratio (ACR)  BP | | | | | |
| **Additional information:** | | | | | | | | | | **Other:** | | | | | | | |
|  | | | | | | | | | |  | | | | | | | |
| Signature: | | | | | | | | | | Date: | | | | | | | |