DIABETES CARE CENTRE REFERRAL FORM

BON SECOURS HOSPITAL
Glasnevin, Dublin 9
Modern Healthcare, Traditional Values

(All fields must be completed)
Please fax completed form to **01 8082343**

REFERRER DETAILS

Name: _____

Address: _____

_____

Tel: _____ Fax: _____

Signature: _____

PATIENT DETAILS

Name: _____

Address: _____

_____

Tel: _____

DOB: _____

CONSULTATION REQUEST

Level 1:	Education Consult – Dietician and Diabetic Nurse	O
Level 2:	Medical & Educational Consult - Endocrinologist, Dietician and Diabetic Nurse	O
Level 3:	Medical and Education Consult - Endocrinologist, Ophthalmologist, Podiatrist, Dietician and Diabetic Nurse	O

PATIENT HISTORY:

CURRENT PATIENT WEIGHT: _____

PATIENT DIAGNOSIS:

BLOOD TEST RESULTS please attach the most recent and complete the following:

Fasting Glucose	_____	Lipids	_____	Bone Profile	_____
HbA1C	_____	Cholesterol	_____	Renal	_____
OGTT	_____	LDL	_____	Liver	_____
Microalbuminuria	_____	HDL	_____		_____
T4 / TSH	_____	T G	_____	Date blood test completed	_____

CURRENT MEDICATIONS:

Bons Secours Hospital
Glasnevin, Dublin 9
Tel: 01 8065300
www.bonsecours.ie

DIABETES DEPT:
Bookings: Tel: 01 8375111 Fax: 01 8082343