

**REFERRAL FORM  
INTEGRATED DIABETES SERVICE**

Referrals must be submitted by e-RS -

e-RS Primary Care Menu      Speciality: **Diabetic Medicine**      Clinic Type: **All clinic types – send for triage**

**Patient Enquiries:**

Single Point of Contact (SPOC), Herts Valleys Integrated Diabetes Service, Potters Bar Hospital, Potters Bar, EN62RY

Tel: **01707 621152**      Email: [hct.hv.diabetes@nhs.net](mailto:hct.hv.diabetes@nhs.net)

**Practice staff** – please note that the telephone lines are extremely busy. If you have enquiries about receipt of referral/appointment dates please contact the service by e-mail [hct.hv.diabetes@nhs.net](mailto:hct.hv.diabetes@nhs.net)

**INCOMPLETE REFERRALS WILL BE RETURNED FOR COMPLETION  
THIS COULD RESULT IN A DELAY IN PROCESSING YOUR REFERRAL**

This form is to be used for all non-emergency referrals for people with Type 1 or Type 2 diabetes who are requiring an enhanced level of specialist diabetes management.

The following patients should be referred as indicated:

- 1. EMERGENCY FOOT:** if systemically unwell WITH RED, HOT, SWOLLEN foot, spreading infection or signs of CRITICAL ISCHAEMIA, GANGRENE, requires admission to secondary care. Refer immediately to the Acute Medical Team On-Call.
  - 2. PREGNANT WITH DIABETES:** Refer **immediately** to diabetes midwife at Watford General Hospital on 07733 949119 or Diabetes Department at Watford General Hospital on 01923 217553 (Monday-Friday 09.00-16.00)
- N.B. For referral to other trusts please see Urgent Admissions Contact list**

<b>DATE OF REFERRAL:</b>
<b>Patient details</b>
Patient Full Name: ..... NHS No: ..... / ..... / .....      Date of Birth: ..... / ..... / .....      Age: .....      Sex : ..... Address : ..... Postcode : ..... Preferred No: <input type="checkbox"/> Home Tel No : .....      Patient consents to message being left    Y <input type="checkbox"/> / N <input type="checkbox"/> Preferred No: <input type="checkbox"/> Mobile Tel No: .....      Patient consents to message being left    Y <input type="checkbox"/> / N <input type="checkbox"/> Ethnicity: .....      Language: ..... ..... Tick if patient has a disability, requires information in an accessible format or requires additional support <input type="checkbox"/>
Please select all that apply and provide further information <input type="checkbox"/> Interpreter required – Language: ..... <input type="checkbox"/> Cognitive Impairment : ..... <input type="checkbox"/> Hearing Impairment : ..... <input type="checkbox"/> Visual Impairment : ..... <input type="checkbox"/> Mobility Impairment : .....

<input type="checkbox"/> Learning Disability Please advise any adjustments needed to support this patient: ..... Please advise if there is a relative/carer/friend who needs to be informed of any contacts/appointments Name:..... Relationship to patient: ..... Tel no:.....
<input type="checkbox"/> House Bound - home visit required (Not available for podiatry referrals)
Property access and relevant information for home visits:
<b>Patient's GP details</b>
Registered GP:.....
Referring GP/Practice Nurse: ..... Signature: .....
Practice: ..... Practice Code: .....
Practice Address: ..... .....
Practice Telephone: ..... Practice e-mail: .....
Preferred no for virtual review:..... E-mail for correspondence: .....
<b>CONSENT:</b> This referral has been discussed with the patient and the patient consents to relevant information being shared with the service provider.
If not please provide further detail:

<b>REFERRAL DETAILS</b>
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<b>DATE OF DIABETES DIAGNOSIS:</b>
<b>KNOWN DIABETES COMPLICATIONS</b>
<input type="checkbox"/> Peripheral vascular disease <input type="checkbox"/> Peripheral Neuropathy <input type="checkbox"/> Cardiac Event <input type="checkbox"/> Nephropathy <input type="checkbox"/> Retinopathy <input type="checkbox"/> CVA/TIA

<b>ADVICE AND GUIDANCE – if you request advice and guidance your patient will not be offered a face to face appointment</b>
<input type="checkbox"/> <b>Virtual review between GP and Consultant to discuss patient management</b> (eg oral therapy/renal/lipid management) <i>See Guidance</i>
Preferred method of contact:
<input type="checkbox"/> <b>GP Direct</b> Tel No: ..... <input type="checkbox"/> GP e-mail address: .....
<i>If you are requesting advice and guidance by e-RS, telephone or e-mail please give a brief description of the issue you would like to discuss:</i>
<input type="checkbox"/> <b>Urgent Advice – for urgent clinical advice contact the Duty Diabetes Specialist Nurse on 07584 703989</b> This number is for urgent clinical advice only. Do not share with patients, or use to contact the service for admin queries.

<b>REASON FOR REFERRAL</b>
<input type="checkbox"/> <b>DIETETICS</b>
<input type="checkbox"/> DESMOND (Type 2 DM education) for new patient confirmed diagnosis within the year) – <i>Desmond PIL</i> <input type="checkbox"/> Type 2 DM education for patients diagnosed for more than a year

<input type="checkbox"/> DAFNE (Type 1 DM education) <input type="checkbox"/> Dietetic Advice
<i>Please provide further information relating to your reason for referring if appropriate:</i>
<b><input type="checkbox"/> SPECIALIST REVIEW (face to face consultations)</b>
<input type="checkbox"/> Hyperglycaemia/High HbA1c <input type="checkbox"/> Insulin Initiation <input type="checkbox"/> Insulin Management <input type="checkbox"/> GLP-1 Initiation <input type="checkbox"/> Hyperglycaemia due to steroid therapy <input type="checkbox"/> Hypoglycaemia <input type="checkbox"/> Patient on Insulin Pump/ device management <input type="checkbox"/> Pre-pregnancy <input type="checkbox"/> Young Adult/Transition (16-25 years) <input type="checkbox"/> Diabetes Renal -Please refer to <a href="#">West Herts Diabetes Renal Pathway</a> . USS kidneys/autoimmune screen performed Y <input type="checkbox"/> / N <input type="checkbox"/>
<i>Please provide further information relating to your reason for referring if appropriate:</i>
<b><input type="checkbox"/> PODIATRY (See Guidance for assessing diabetic foot risk)</b>
<b>URGENT FOOT:</b> ( If not requiring emergency admission, patient will be seen in the MDT foot clinic within 24 hours. ) <input type="checkbox"/> <b>Ulcer</b> <input type="checkbox"/> <b>Acute Pain</b> <input type="checkbox"/> <b>Infection not responding to standard treatment</b> <input type="checkbox"/> <b>Unexplained foot swelling</b>
<b>INCREASED / HIGH RISK FOOT (Tick all that apply)</b> <input type="checkbox"/> Neuropathy <input type="checkbox"/> Absent pulses <input type="checkbox"/> Foot deformity/discolouration <input type="checkbox"/> Previous ulcer/amputation <input type="checkbox"/> Callous
<input type="checkbox"/> <b>OTHER – please use this section to any enter further information:</b>
<i>Please provide further information relating to your reason for referring if appropriate:</i>

<b>NICE diabetic foot risk categories:</b> Please tick (see table 1 <input type="checkbox"/> for clarification)			
<b>Low:</b> <input type="checkbox"/>	<b>Moderate:</b> <input type="checkbox"/>	<b>High:</b> <input type="checkbox"/>	<b>Ulcerated:</b> <input type="checkbox"/>

<b>COMMENT/ ADDITIONAL INFORMATION TO SUPPORT REFERRAL:</b>
Would this patient benefit from a referral to the Wellbeing Service?

Insulin (including doses); Please complete this section if possible/relevant.				
Insulin	Breakfast	Lunch	Evening	Pre Bed


Investigations within the last 6 months	
Height (metric)	
Weight (kg) / BMI	
LFTs	
BP (mmHg)	
HbA1c IFCC (%/mmol/mol)	
HbA1c DCCT (%/mmol/mol)	
Total Cholesterol (mmol/L)	
HDL – chol (mmol/L)	
LDL – chol (mmol/L)	
TGs (mmol/L)	
eGFR (mL/min)	
Urine ACR (mg/mmol)	

Current Medication:
Problems – Active and Inactive
Allergies

Table 1: NICE diabetic foot risk categories	
Assess the person's current risk of developing a diabetic foot problem or needing an amputation using the following risk stratification:	
<b>Low Risk</b>	* no risk factors present except callus alone
<b>Medium Risk</b>	*deformity or *neuropathy or *non-critical limb ischaemia
<b>High Risk</b>	*previous ulceration or *previous amputation or *on renal replacement therapy or *neuropathy and non-critical limb ischaemia together or *neuropathy in combination with callus and/or deformity or *non-critical limb ichaemia in combination with callus and/or deformity
<b>Active diabetic foot problem</b>	*ulceration or *spreading infection or *critical limb ischaemia or *gangrene or *suspicion of an acute Charcot arthropathy, or an unexplained hot, red, swollen foot with or without pain