



## **INTEGRATED CARE DIABETES REFERRAL FORM**

OFFICE USE: Dear SPA Colleagues - If for Wellbeing please allocate to Team admin account once risk reviewed

Name & Surname		Gender		
NHS number		Ethnicity		
Telephone		DOB		
Patient Address		GP Name & Practice		
GP informed of referral? Yes/No		Patient aware of	referral?	Yes/No

Is your patient: Pre-diabetic Diabetic	(type 1) Diabetic (type 2)				
Most recent HbA1C level: (mmol/%) Date of reading:					
Date of test:					
Referral source (please tick): Primary care	HCT Hospital				
Referrer Details (name/contact number/ bleep):					
Consultant name:					
Reason for referral (please tick as many as apply):					
Frequent attender (e.g. A&E, drop in, calls)	Multiple unscheduled admissions				
Poor self management of diabetes	Adjustment to Initial diagnosis				
Anxiety about managing diabetes	Non compliance with meds or diet				
Depression/ low mood Generalised anxiety OCD PTSD Social Anxiety Stress Panic Phobia Needle Phobia	Anger Management Pain management Bereavement Self harm Eating Disorder				
Other (please specify):					
Please state any medical complications as a result of diabetes: (e.g. eye, kidney, foot, cardiovascular)					
Mental Health history:					
Does the patient have a formal psychiatric diagnosis? Yes/No					
(e.g. Schizophrenia/ BipolarAffective Disorder/Personality Disorder/Eating Disorder) please circle					

	Waa / Na				
	Yes / No	T.,			
Is your patient currently under the care of mental health services?	Is your patient currently prescribed medication for mental health problems?  Yes / No	ion for mental health problems?   inpatient on a psychiatric unit?			
Yes / No					
		Yes / No			
If yes to any of the above please	e provide details.				
Please give history of Alcohol and/or Drug Use e.g. units of alcohol typically consumed, name and frequency of use of illicit drugs					
RISK ASSESSMENT:  Does the patient have a history of self-harm or suicide attempts?  Yes/No					
Does the patient present a risk to	Yes/No				
Is the patient at risk from harm/	Yes/No				
If yes to any of the above please provide detail (e.g. level of risk, protective factors):					

- 1. If your patient is being cared for within primary care or Herts Community Trust please refer to: WELLBEING: Please hand the completed referral to your allocated Wellbeing therapist or email this referral form to: <a href="https://hpft.spa@nhs.net">hpft.spa@nhs.net</a>
- 2. If your patient is under the care of West Herts Hospital Diabetes Team please refer to: Complex Diabetic Mental Health Team, 2<sup>nd</sup> Floor, Shrodells Building, Watford General Hospital, Watford, WD18 0HB email: <a href="mailto:r.watford@nhs.net">r.watford@nhs.net</a> or Fax: 01923 436123 Phone: 01923 436124