Government of **Western Australia**
Department of **Health**
South Metropolitan Area Health Service

Fax Number: 08 9431 2338

Initiation of Insulin Therapy and Stabilisation in an Ambulatory Setting

Referral to: Date of referral:
Surname: **First Name:**
Address **Suburb:** **Post Code:** Home Phone: Business: Mobile:
Date of Birth:
Referring Doctor: Dr **Address:** **Suburb:** **Post Code:** **Business Phone:** **After Hours:** **Mobile:** **FAX :** Email:
Type of diabetes: Type 1: [ ] Type 2: [ ] Gestational: [ ]
Date of Diagnosis:
Laboratory test results: Hba1c: % **BGL:** Ketones: *Please attach other relevant results*
Current Treatment:
Insulin Therapy Order:
Type of Insulin: Starting dosage: Time and regimen:
Size of incremental adjustment**:**
Target blood glucose range: Fasting [ ] Post Prandial [ ] as per NRMHC guidelines
In Type 2 diabetes, is current oral therapy to be continued as combination therapy? Yes [ ] / No [ ] *If yes, please state type of oral agent and dosage.* *If no, please state which oral agent is to be ceased.*
*Case Management For Patient Commencing Insulin Therapy In An Ambulatory Setting * Please tick appropriate section otherwise referral is INVALID – **[ ]** The referring doctor wishes the diabetes educator to assist and teach self management of ongoing insulin dose adjustment by 2-6 units until blood glucose levels are with in 4-10mmol/L. [ ] The referring doctor will manage ongoing insulin dose adjustment.
Expectations for progress reports: Weekly [ ] Fortnightly [ ] **3 Monthly [ ]**
Signature and Stamp: