

Insulin Therapy Order – Wheatbelt GP Network (For use by Diabetes Educator only) To be completed by referring medical officer

Client Details:		Date of Referral:	
Surname:		First name:	
Address:			
Home Tel:		Work Tel:	
Date of Birth:		Mobile:	
Type of Diabetes:	type 1 <input type="checkbox"/>	type 2 <input type="checkbox"/>	gestational <input type="checkbox"/>
Laboratory test results:	HbA1c: %	BGL:	mmol/L
Urine Ketones:	Please attach other relevant test results		
Current treatment:			
In type 2 diabetes, is current oral therapy to be continued as "combination therapy" Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please state type and dose of oral agent(s) to be taken			
Case Management for client commencing Insulin Therapy in the Ambulatory setting Please tick appropriate section otherwise referral is INVALID			
<input type="checkbox"/> Referring doctor wants Diabetes Educator to adjust insulin doses until BG targets achieved			
<input type="checkbox"/> Referring doctor will adjust insulin doses			
Insulin Therapy Order			
Type (s) of Insulin:	Starting Dose:	Time and regime:	
Target blood glucose range:			
Fasting:	Post prandial:		
Size of incremental adjustments:			
Referring Doctor:			
Practice:			
Address:			
Work Telephone:			
Signature:			