

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:	irst name:	
Address:					
Home Tel:		Work Tel:			
Date of Birth:			Mobile:		
Type of Diabetes:	type 1 □		type 2 □	gestational	
Laboratory test results:	HbA1c:	%	<u> </u>	BGL:	mmol/L
Urine Ketones:	Please attach other relevant test results				
Current treatment:	1.10000 0110011 01110	0 0.0.0			
In type 2 diabetes, is curre	ent oral therapy to I	be conti	nued as "combin	ation therapy"	
	s, please state type				
,	31			,	
Case Managem	ent for client comm	nencing	Insulin Therapy	in the Ambulatory	/ setting
Case Management for client commencing Insulin Therapy in the Ambulatory setting Please tick appropriate section otherwise referral is INVALID					
Please lick appropriate	section otherwise	e referr	al is INVALID	J	J
Please lick appropriate	section otherwise	e referr	al is INVALID	_	3
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Authorised by Network Services Manager	Revision 1
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