Empowering people with diabetes to manage their condition and live happier, healthier lives

Referral to Diabetes Self Management Education
For Adults with Type 2 Diabetes, Pre Diabetes

Patient information				**Referrer information**	
Date		**NHI**		**GP Name**	
Surname		**First Names**		**Practice Nurse Name**	
Gender		**DOB**		**Practice Stamp**	
Address				**Reason for Referral**	
Phone √ **Preferred Contact**	Home:	Mobile:			

Ethnicity			
	Maori	Indian	Year Diagnosed:
	European NZ	Asian	
	Pasifika	Other	
	Specify	Specify	Prediabetes

Consent for:
DSME
Yes ☐ No ☐

Consent for:
Green Prescription
Yes ☐ No ☐

Patient Preference			
Ethnic Specific	Language Spoken	Men only	Women only

Preferred Session Days and Times

Weekdays	Weekend	Daytime	Evening

Preferred Course Location	

Consent: I confirm that I have explained Diabetes Self Management Education (DSME) and Green Prescription process. The patient has consented for their details and clinical information to be forwarded to DSME and Green prescription

Referring Health Professional: ______________________________

Date: ________________

Clinical Information			
HbA1c			
ACR			
Serum Creatinine			
Blood pressure			
TC/HDL Ratio			
Triglycerides			
Year of Diagnosis		**Yes**	**No**
Diabetes Medication	**Diet only**		
	Tablets		
	Insulin		
Height:	**Neuropathy**		
	Nephropathy		
Weight:	**Dialysis**		
	Retinopathy		

FAX TO 379 4024