NHS Hounslow Clinical Commissioning Group

NHS Central London Community Healthcare NHS Trust
Barnet | Hammersmith and Fulham | Kensington and Chelsea | Westminster

Hounslow Diabetes Intermediate Care Service Referral Form

Routine and urgent telephone helpline: **07815716838**
Email contact for routine clinical queries: **CLCHT.HounslowDiabetesICSService@nhs.net**

Patient	**Referrer**
Name: Address: Home: Mobile: DoB: Age: NHS Number: Email: Gender:	Name: GMC no: Practice e-code: Practice Address: Telephone: Fax: E-mail: @nhs.net Referred by if not GP: PN ☐ Enter name: Other Enter name and job role.

Assistance with Booking	Yes ☐ No ☐	Interpreter Required	Yes ☐ No ☐
Transport Required	Yes ☐ No ☐	Language	
Consent to share record	Yes ☐ No ☐	Ethnicity	
Mental Health/ Learning Disability	Yes ☐ No ☐	Referral Date	

Patient Locality:

Locality: HOH ☐ Feltham ☐ Chiswick/B&I ☐ Great West ☐
Patient to be seen in joint clinic (where arrangements are in place with locality)

Referral to Patient Education:

Holding Off (Pre Diabetes) ☐ Type 2 X-pert ☐ Type 2 X-pert Insulin ☐ Conversation Maps ☐
Diabetes Type 1 Education ☐

Referral To:

Consultant ☐ DSN ☐ Dietician ☐ Psychology ☐

Reason for Referral

Poor control and on maximum tolerated oral agents up to triple therapy ☐
Recurrent hypoglycaemic episodes
Poorly controlled hypertension or hyperlipidaemia ☐

Referral Priority/ Patient Access

☐ Routine ☐ Urgent, please give reason

Patient will attend clinic ☐ Patient requires domiciliary care ☐ Joint home visit with GP/ practice nurse ☐

Diagnosis and Relevant Medical Details

Please complete all sections: Diagnosis: Year of Diagnosis:

Result		**Date**	**Result**		**Date**
BP:			**HbA1c:**		
Weight:			Total Cholesterol:		
Height:			HDL:		
BMI:			LDL:		
			TG:		

Please send referrals to the **REFERRAL FACILITATION SERVICE:**
as an **email attachment to Hounslow.RFS@nhs.net** (This is a secure NHS email address)**.**
For practice enquires please telephone: 05511 434910

Patient Name: <Patient Name> NHS no. <NHS number> Date: <Today's date>

Result		Date	Result		Date
Creatinine:			GFR:		
ACR:			DESP:		
Smoking Status:			Alcohol intake		

Foot assessment risk:

Diabetic Foot Risk Status for Scored Assessment:

History, Past Medical History, Medication, Allergies, Examination

Past Medical History -- Include **only relevant** medical history:

Summary

Current Acute Medication in the last 1 month

Current Repeat Medication

Allergies

Other clinical information

Please state secondary care provider if referral requires secondary care input. If preference is not indicated provider will be assigned by postcode.

West Middlesex ☐ Imperial College ☐ Chelsea & Westminster ☐ Ashford & St Peters ☐
Ealing ☐ Other (please Specify)

Please note, incomplete referrals will be returned to the referrer.