Clear form

# Insulin Initiation Medication Referral

**send with VSRF**

Doctor's stamp

After Hours Phone:_____

Fax to: Caulfield Community Health Service - 9076 4060

## 1. Client Details

Date of Birth:

Last Name: First Name:

Address:

Suburb: Postcode:

Contact Number:

## 2. Pathology/Medical Exam Results

HbA1c (within last month): % Date:

Fasting/Random BGL: mmol/L Date:

Other relevant results:

***Please attach pathology lab reports***

## 3. Adjustments to current diabetes medications and/or steroids

## 4. Insulin Therapy Requested

| | Type of Insulin: | Starting Dose: | Frequency: |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

## Guidelines for adjustment only*

| Basal (peakless) insulin/Premix insulin | | | |
|---|---|---|---|
| **Average FBG** | **Dose Adjustment** | **Average FBG** | **Dose Adjustment** |
| >10 | ↑ by 2 - 4 units | 6 – 6.9 | No change |
| 8 – 9.9 | ↑ by 2 – 4 units | 4 – 5.9 | ↓ by 2 units |
| 7 – 7.9 | No change OR ↑ by 2 units | < 4 | ↓ by 2 – 4 units |

**I am aware the Diabetes Nurse Educator will adjust the above patient's insulin doses and review their BGL's according to the orders I have provided to assist in the management and stabilisation of the patient's diabetes.**

Referring Doctor's Signature:_____ Date:_____

**GP/specialist will be contacted by the DNE if hypo/hyperglycaemic etc. events occur.**

***NB: If insulin has not commenced within 8 weeks from date of referral, please confirm orders before initiation***

**See RACGP General Practice management of type 2 diabetes 2016-18 for full adjustment guidelines*

**Updated: August 2017**