Clear form

Southern Melbourne Primary Care Partnership

Insulin Initiation Medication Referral

send with VSRF

Doctor's stamp

Fax to: Click here to choose service

After Hours Phone:_____

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