Diabetes "Super 7" Specialist Service

Referral Form

University Hospitals of Leicester NHS
NHS Trust

Working in partnership with CCG's across Leicester, Leicestershire and Rutland

NHS Number:	**Referral Date:** D D M M Y Y
Patient Details:	**Patient Consent:**
Name:	
Address:	
Postcode:	Diabetes: Type 1 ☐ Type 2 ☐
DOB: D D M M Y Y Gender: M ☐ F ☐	
Patient Tel:	Interpreter required? Yes ☐ No ☐
Mobile:	Preferred language:
Carer contact details (if appropriate)	

GP Practice Details:	
Name:	
Address:	
Postcode:	Contact Number:

Biomedical Results: (most recent) please attach list of current medication and medical history

	Result	Date
HbA1c (mmols/mol)		D D M M Y Y
Previous HbA1c (mmols/mol)		D D M M Y Y
BMI		D D M M Y Y
eGFR		D D M M Y Y

Clinic Referral Requested		Brief comments
Pump or pre-pump	☐	
Foot	☐	
New and Complex T1 (See overleaf)	☐	
Complex T2 (See overleaf)	☐	
Renal (3b with increasing proteinuria) or	☐	
Renal (CKD 4/5)	☐	
Pregnancy	☐	
Type 1 pre - conception	☐	
Young person 16-19 yrs	☐	

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PTO

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COMPLEX TYPE 1:	Please give details:
For example: Under 25 years ☐ Severe hypoglycaemia Persistent poor glycaemic control	

COMPLEX TYPE 2:	Please give details::
For example: Under 40 years ☐ BMI > 40 Persistent poor glycaemic control Significant insulin resistance Off Licenced use of combination of glucose lowering drugs NAFLD / NASH	

ANY OTHER	Please give details:
Please give adequate clinical information to justify referral to specialist service ☐	

Referrers Details:	
Name:	
Designation:	Signature:

Please fax/send this form to: Diabetes Outpatients, Leicester General Hospital, Gwendolen Road, Leicester LE5 4PW
Fax /Tel: 0116 273 4845

Designed by S.Jamal Diabetes UHL
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