**Guidance for Community Professionals making referrals to the**

**Adult Community Diabetes Specialist Nursing (DSN) team**

**General information**

* The DSN service **is not an emergency service** – the patient referral will be prioritised in relation to clinical need
* Patients will be assessed and treated in clinic or the domiciliary setting. If the patient has a disability or specific needs which may lead to difficulty accessing the service, the referrer should provide the relevant information.
* Staff should be alerted to any known risks whether that is in relation to inappropriate behaviour in clinic or risks involved with domiciliary visits.
* Patients with diabetes planning a pregnancy should be referred to the nurse-led pre-pregnancy service.

**Patient categories**

1. Patients with Type 1 Diabetes who are poorly controlled.
2. Patients with Type 2 Diabetes on maximum tolerated oral hypoglycaemic medication (with an HBA1C >70mmol/mol).
3. Patients on insulin where practices not familiar/confident with advising on insulin dose adjustment.
4. Patients to commence insulin/ injectable GLP – 1RA.
5. Patients on insulin therapy requiring advice on travel, driving and other lifestyle issues.
6. Patients who need to change their insulin regimes or injection devices. If there are Drug supply issues then GP Practice to follow DoH guidance.
7. Patients with frequent and/or unawareness of hypoglycaemia.
8. Patients with diabetes and concurrent medical problems, exacerbating their diabetes management.
9. End of life patients on Insulin.

**Patient exclusion criteria**

* Patients aged under 18 years (unless diagnosed within 1 month of 18 years)
* Patients not on maximum oral anti-hypoglycaemic medication

**Classification for urgent and non-urgent referrals**

**Urgent referral criteria**

* Type 1 diabetes, acutely unwell, hyperglycaemic +/- ketones
* Steroid induced diabetes/steroid induced hyperglycaemia requiring insulin
* Hypoglycaemia (requiring third party intervention)
* **Urgent referrals: will be contacted within 2 working days (via telephone or face to face)**
* **Non urgent referrals: will be triaged and appointment arranged if appropriate**

**DSN Referrals**

**Only electronic referrals will be accepted on the attached referral form.**

*Please note that if the referral does not meet criteria or there is missing information, it will be returned to the referrer.*

Please send all community DSN referrals to:

**DiabetesSpecial.Nurse@southerntrust.hscni.net**

Telephone Hub Number: (028) 3756 1010

September 2019

# DIABETES SPECIALIST NURSE REFERRAL FORM

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**H & C No:**

|  |  |
| --- | --- |
| **NAME:** | **GP:** |
| **D.O.B.** | **GP ADDRESS:** |
| **ADDRESS:****POSTCODE:****TEL. NO.** | **TEL. NO:****GP e-mail address:** |
| **PATIENT AWARE OF REFERRAL AND GIVEN CONSENT:**  Yes **🞏** No **🞏** |
| **DIABETES SPECIALIST DIETETIC REFERRAL DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **TYPE OF DIABETES:**  **DATE OF DIAGNOSIS:**  | **IS PATIENT BLOOD GLUCOSE MONITORING?** Yes **🞏** No **🞏** |
| **In last 3 months:** **HbA1c Result \_\_\_\_\_\_\_mmol/mol****eGFR Result \_\_\_\_\_\_\_\_ml/min** | **Current****WEIGHT : \_\_\_\_\_\_\_\_kg** **BMI: \_\_\_\_\_\_\_\_\_\_kg/m2**  |
| **LONE WORKER ISSUES?** Yes **🞏** No**🞏** **If yes please specify:** |
| **FIRST LANGUAGE:****INTERPRETER REQUIRED?** Yes **🞏** No **🞏** |
| **REASON FOR REFERRAL:** |
| **CURRENT DIABETES TREATMENT & MEDICATIONS:** (This section must be completed or form will be returned) |
| **ALLERGIES (IF KNOWN):** |
| **RELEVANT MEDICAL HISTORY:** |
| SIGNED:**PROFESSION:** | DATE: | CONTACT NUMBER: |
| **OFFICE USE ONLY****REFERRAL APPROPRIATE: YES/NO DATE RECEIVED: ACTION TAKEN:** |

**Please return by e-mail to:** **DiabetesSpecial.Nurse@southerntrust.hscni.net**