



# General Practitioner Referral Form

to a Lifestyle Modification Program under the prevention of type 2 diabetes program

## Referral Date

 /  / 

(Referral is valid for two months from the referral date provided above)

Note: Patient must be between 40-49 years, or an adult Aboriginal or Torres Strait Islander (15 – 54 years) and be at high risk of type 2 diabetes to be eligible for the program.

Has type 2 diabetes been excluded?  Yes  No Note: type 2 diabetes must be excluded to be eligible for the program.

## Patient/Client details

Title (please circle) Mr Mrs Ms Miss Other \_\_\_\_\_

Surname

Given Name/s

Preferred name/s

Date of Birth

 /  / 

Sex (please circle)

M F

Country of Birth

Health Care Card

Concession Card

Is the patient of Aboriginal or Torres Strait Islander descent?  Yes  No

Are there any cultural or religious reasons that may inhibit the patient from attending or participating fully in a Lifestyle Modification Program?  Yes  No  Unsure

If yes or unsure, please provide details \_\_\_\_\_

## Clinical Information

Waist circumference

 cms

Weight

 kgs

Height

 cms

**Current medical, physical or other limitations that may affect the person's capacity to fully participate in the program**

**What advice have you given the patient in regard to management of limitations during the Lifestyle Modification Program?**

**What advice have you given this patient in relation to possible effects of lifestyle modification of his/her medical conditions or medication regime?**

# General Practitioner Referral Form

<b>Referral to Lifestyle Modification Program</b> Name of provider <input type="text"/> Address <input type="text"/> <input type="text"/> Postcode Phone <input type="text"/> Fax <input type="text"/> Email <input type="text"/> Website <input type="text"/>	<b>Referring General Practitioner (stamp):</b>  By signing below, you are confirming that the patient does not have existing type 2 diabetes and can safely participate in a Lifestyle Modification Program, given any necessary adaptations described above.  Provider Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> General Practitioner Signature <input type="text"/>
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Completed Risk Assessment Tool attached?  Yes – Note: Completion of the Risk Assessment Tool is mandatory.  
 No

Score

## Patient information and consent to use of personal information

Some of the administration for the provision of Lifestyle Modification Programs is being managed by local Divisions of General Practice. Accordingly, it will be necessary for the personal information about you on this form to be given to that Division of General Practice.

The Division of General Practice will be required to keep the information about you in a way that protects your privacy. The Division will not be permitted to disclose information about you to anyone else. Some data which will not identify you will be given to the Commonwealth Department of Health and Ageing and also to the Australian General Practice Network so that the Program can be monitored and evaluated.

By signing this information and consent to disclosure section, you are saying that you understand the above procedures and that you are giving consent to the Lifestyle Modification Program provider to give your personal information to the Division of General Practice.

Signature  Date  /  /

## EVIDENCE OF CLIENT ENROLMENT

To be completed by the LMP provider

Date of initial client contact with LMP provider

/  /

Proposed course commencement date

/  /

Address of planned location of course

Postcode

Provider signature

Provider name

Date