FAX BACK TO : 01 6639867

Diabetes Clinic Referral Form

Name of GP referring/Practice:_____

Name of Patient: _____

Address: _____

_____

Contact number: _____

Date of birth: _____

Date	Fasting Blood Glucose	Random Blood Glucose	HbA1c	Total cholesterol	Triglyceride	LDL cholesterol	HDL cholesterol

Oral glucose tolerance (OGTT) only indicated if patient does not have two abnormal results:

Fasting ≥ 7.0 mmol/l, or Random ≥ 11.1 mmol/l, or HbA1c ≥ 48 mmol/mol.

OGTT results: (date:) fasting =_____ **2-hour post =**_____

Medications: _____

_____

_____

Comments:_____

_____

_____

Please mail or fax (6639867) completed form to Nurse Ann Fitzpatrick, Diabetes Centre, St. Michael's Hospital,, Dun Laoghaire, Co. Dublin