



Insulin Initiation Medication Referral

send with VSRF

Doctor's stamp

Fax to:

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: _____

Other relevant results:

Fasting/Random BGL: _____

mmol/L

Date: _____

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 *

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's 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 with GP before initiation