

Clients Name: _____ M / F

Address: _____

D.O.B: _____ / _____ / _____

Telephone No (NB*): (H)(_____) _____ (M)(_____) _____

GP name: _____ **GP address:** _____

Newly Diagnosed (last 12 months) Yes/ No
Ongoing (If Longer than 12 months) Yes/ No
Client Consent for Referral: Yes/ No
Client Consent to Receive (Appointment Reminder) Text alerts Yes/No

Clinical information required:

Date of appointment/visit:	
HbA1c (mmol/mol)	
Total cholesterol (mmol/l)	
HDL (mmol/l)	
LDL (mmol/l)	
Triglycerides (mmol/l)	
Systolic BP (mmHg)	
Diastolic BP (mmHg)	
Weight (kg)	
Waist (cm)	
Smoking	Yes/No

Fasting Yes/No

Referral Signature:..... G.P / Nurse / HP / Self

Contact Details:..... **Date:**.....

Please send/fax referral to: DESMOND Co-ordinator
 Community Nutrition and Dietetic Service
 Willow Unit
 St Josephs Hospital
 Lifford Road
 Ennis, Co. Clare
Phone: 065 6863556