MonashHealth
Monash Diabetes

REFERRAL GUIDELINES
DIABETES SERVICES

Referral Form: The GP Referral Template is the preferred referral tool (previously known as the Victorian Statewide Referral Form) – GP Referral Template

This tool is housed in most major clinical software or can be downloaded from

We aim to provide prompt efficient patient centred care to achieve the Monash H exceptional care and outstanding outcomes. We work in partnership with our p GP's and other service to support those with diabetes to optimise care and clinic Many of our services provide interim support to GPs and patients, others are ch management services only for the most complex of patients. We appreciate feec happy to hear how we can improve our services.

Click on a Diabetes Service to advance to that section:

- Diabetes Support Service (DSS)
  - Dandenong Hospital
  - Monash Medical Centre, Clayton
  - Berwick Healthcare
  - Kooweerup
- Chronic Disease Management Clinic (CDM)
  - Dandenong Hospital
  - Monash Medical Centre, Clayton
- Diabetes in Pregnancy Service (DIPS)
  - Dandenong Hospital
  - Monash Medical Centre, Clayton
  - Cranbourne Integrated Care Centre
  - MonashLink Community Centre, Clayton
- Young Adolescent Diabetes Service (YADS)
  - Dandenong Hospital
  - Monash Medical Centre, Clayton
- Diabetes Fast Track Clinic
  - Dandenong Hospital
  - Monash Medical Centre, Clayton
- High Risk Foot Clinic
  - Dandenong Hospital
- Diabetes, Vascular Medicine and Hypertension Clinic
  - Dandenong Hospital
- Diabetes Hospital Admission Risk Prevention Clinic
  - Dandenong Hospital
  - Monash Medical Centre, Clayton
- Acute Diabetes Oncology Service
  - Monash Health, Moorabbin

PLEASE INCLUDE THE FOLLOWING ON THE REFERRAL:

Demographics:
- Full name
- Date of birth
- Postal address
- Landline & mobile number
- Medicare number
- Referring GP detailsand provider number
- Usual GP (if different)
- Interpreter requirements

Clinical:
- Reason for referral
- Duration of symptoms
- Type of Diabetes (Type 1 / Type 2 / Gestational / Other)
- Medications
- Latest HbA1C
- Latest Pathology test results
  - Fasting Gluc
  - U&E
  - OGTT (GDM only)
  - Chol/HDL/LDL/TG
  - Urine ACR
- Management to date and response to treatment
- Past medical history
- Current medications and medication history if relevant
- Any significant psychosocial factors. Eg. Mental illness

HEAD OF UNIT
Dr Helena Teede

OUTPATIENT ENQUIRIES

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Services not provided at Monash Diabetes:

- Routine Uncomplicated Diabetes Care
- Diabetes education and Dietitian review if Specialist management opinion is not required

PLEASE NOTE: All referrals received by Monash Diabetes are triaged by Senior Endocrinologists to determine the eligibility and urgency of referral. Low quality referrals with missing data may be returned with requests for missing information.

- Patients assessed as having an **urgent** need are offered an appointment within 6 weeks as assessed by the clinician.
- Patients assessed as having a **non-urgent** need for appointments in clinics will be offered the next available appointment.

Where the wait time does not meet patient needs, alternative service providers can be found by searching the Human Services Directory at http://humanservicesdirectory.vic.gov.au/Search.aspx

Diabetes Support Service (DSS)

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The DSS is run on a Wednesday morning at the Clayton and, Dandenong sites and at Casey hospital on Wednesday afternoons. These multidisciplinary clinics are overseen by a lead clinician who supervises a number of medical staff, ranging from trainees to staff endocrinologists. The clinic is also staffed by a Nurse Practitioner, dietician and experienced diabetes educators.
The DSS clinics are a short term service (generally 2 to 3 appointments) where, once stabilised, patients will generally be returned back to the care of their GP as their primary care provider. They can be referred again as needed for future episodes of care.

For the most complex patients, medical staff or the Nurse Practitioner working in the DSS clinics may refer patients directly into Chronic Disease Management (CDM) for ongoing hospital based follow up.

WHEN TO REFER

- Patients sent home from ED with hypo or hyperglycemia who require rapid assessment;
- Patients recently discharged from hospital with:-
  - Unstable diabetes
  - Significant changes to therapy initiated during admission
- Severe recurrent hypo/hyperglycaemia (<2.5mmol/L or >14mmol/L) despite adjustments in therapy.
- Poorly controlled diabetes
- Suboptimal diabetes management where patient has underlying mental illness;
- Suboptimal diabetes control where patient has numerous diabetic complications (micro or macrovascular).

Initial GP Work Up

- HbA1C
- Fasting Glucose
- U & C
- Fasting Cholesterol - HDL, LDL, TG
- Urine ACR

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Chronic Disease Management Clinic (CDM)

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The CDM clinics are run at Monash Clayton and Dandenong on Thursday mornings. They are multidisciplinary clinics staffed by consultant endocrinologists, diabetes nurse educators, a dietician and podiatrist. Point of care HbA1c testing is performed in all patients unless this has been performed within the last 3 months.

Please note that patients from the community cannot be referred directly into this service. These patients must always be initially assessed in the Diabetes Support Service (DSS).

WHEN TO REFER

- Patients with multiple complications of diabetes eg chronic kidney disease or multiple vascular complications eg IHD, stroke, leg ulceration, Charcot's arthropathy
- Patients with sub-optimally controlled diabetes who are non-English speaking;
- Patients with suboptimal diabetes control who have co-existent mental illness.

Initial GP Work Up

- HbA1C
- Fasting Glucose
- Fasting Glucose
- U & C
- Fasting Cholesterol - HDL, LDL, TG
- Urine ACR

Diabetes in Pregnancy Service (DIPS)

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The DIPS service currently runs across a number of sites including Monash Clayton (Tuesday am), DDH (Friday am), Cranbourne Integrated Care Centre (Friday pm) and MonashLink, Clayton Community Centre (Friday morning). These multidisciplinary clinics are staffed by endocrinologists, diabetes educators and dieticians. The DIPS at Dandenong, Cranbourne and MonashLink manage women with GDM ONLY, while women with T1DM and T2DM are all managed in the Clayton DIPS service.

WHEN TO REFER

- Women with pre-existing T1DM or Type 2 diabetes (T2DM) for pre-conception counselling
- Women with pre-existing T1DM and T2DM who are pregnant (**EARLY referral is recommended**);
- Women with newly diagnosed gestational diabetes (GDM) (**EARLY referral is recommended**);
- Women found to have an elevated random glucose in early pregnancy.

Initial GP Work Up

- OGTT (for GDM women only)
- HbA1C (for T1DM and T2DM)
- Fasting Glucose
- U & C(for T1DM and T2DM)
- MicroAlb, ACR(for T1DM and T2DM)

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Young Adolescent Diabetes Service (YADS)

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YADS clinics' are multidisciplinary clinics staffed by paediatric and adult consultant endocrinologists, diabetes nurse educators, dietician, social worker (Monash site only) and optometrist (DDH site only) and provide point of Care HbA1c measurement.

Please note this clinic does NOT provide services for T2DM.

Dandenong:
Young adults aged between 18-30 years living in the Dandenong and Casey Hospital catchment areas. When: Thursday evenings 4:00 pm - 7:30 pm, 2 evenings a month (usually 2nd and 4th Thursday evening)

Monash Clayton:
Fifteen year olds with diabetes are transferred from the MMC Paediatric Diabetes clinic to YADS, and are initially managed by the same paediatric consultant. At the age of 18 – 19 years, over a period of 6 – 12 months the teenagers are prepared for transition to one of the YADS adult consultants, with continuity of consultant care maintained.

When: Monday evenings 5:00 pm - 8:30 pm, 2 evenings a month (usually 1st and 3rd Monday evening)

NB: GP's are requested to refer onto this service using the Victorian Statewide Referral Form housed in most clinical software. More information on VSRF – www.gpv.org.au then click on Resources or contact your local Divisions of General Practice.

WHEN TO REFER

- Young Adults aged between 18-30 years with uncontrolled Type 1 Diabetes

Initial GP Work Up

- HbA1C
- Fasting Glucose
- U & C
- Fasting Cholesterol - HDL, LDL, TG
- Urine ACR
- TFT's
- Coeliac Serology

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High Risk Foot Clinic

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The High Risk Foot service offers patients a multidisciplinary model for integrated, comprehensive (including community, ambulatory and inpatient) care for the prevention and treatment of diabetes related foot complications.

The clinic aims to prevent deterioration and maintain the healed high risk foot by providing high risk care coordinators for complex care between community and acute, whilst also looking well beyond the foot to focus on the physical, psychological and social challenges of the patient.

WHEN TO REFER

- People with Diabetes and a history of ulceration / amputation or active early stage ulceration against a background of peripheral neuropathy or PVD
- Patients with complex ulceration, infection and amputation as a result of their underlying medical condition

Initial GP Work Up

- HbA1C
- Fasting Glucose
- U & C, LFT's / FBE
- Fasting Cholesterol - HDL, LDL, TG
- Urine ACR

Diabetes Fast Track Clinic

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Patients triaged for the Diabetes Fast Track Clinic have recently been discharged from hospital and require follow up within 2-3 weeks. They are seen in clinic up to 3 times prior to discharge back to GP (if medically stable) or to a long term clinic based on their assessed need. Fast Track Clinic at DDH occurs every Tues morning whilst Fast Track Clinic at MMC occurs every Wed morning alongside the Diabetes Support Service Clinic. This clinic is staffed by a Nurse Practitioner.

WHEN TO REFER

- Patients sent home from ED with hypo or hyperglycemia who require rapid assessment;
- Patients recently discharged from hospital with:-
  - Unstable diabetes
  - Significant changes to therapy initiated during admission

Initial GP Work Up

- HbA1C
- Fasting Glucose
- U & C
- Fasting Cholesterol - HDL, LDL, TG
- Urine ACR

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Diabetes, Vascular Medicine and Hypertension Clinic

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Patients with diabetes and vascular complications/hypertension can be referred to this clinic. The clinic operates at Dandenong Hospital once per fortnight on Wednesdays 1:30 pm – 5:00 pm and is staffed by a vascular physician.

WHEN TO REFER

- Diabetes with vascular complications/hypertension
- Medical review of pre-operative Vascular Surgery patients
- Post-operative diabetes /vascular follow up of surgical patients
- Follow up of pregnancy associated blood pressure
- Difficult CV risk management
- Primary and secondary hypertension
- Complex vascular arterial or venous disease
- Thrombotic disturbances
- Vasculitic diseases

Initial GP Work Up

- HbA1C
- Fasting Glucose
- U & C
- Fasting Cholesterol - HDL, LDL, TG
- Urine ACR

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Diabetes Hospital Admission Risk Prevention Clinic (HARP)

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The Hospital Admission Risk Program (HARP) aims to prevent avoidable hospital presentations and admissions. HARP targets people with complex care needs that frequently use hospitals or are at imminent risk of hospitalisation and could benefit from coordinated care. This may include people with a chronic disease, conditions of ageing or psychosocial complex needs. Health services may have people who present frequently for many different reasons. HARP specialises in managing people with diabetes, chronic respiratory disease, and chronic heart disease, complex psychosocial and complex aged needs.
HARP provides specialist medical care and multidisciplinary services through an integrated response of hospital and community services, delivered in hospital, community and home-based settings.

WHEN TO REFER

- Patients sent home from ED with hypo or hyperglycemia who require rapid assessment;
- Patients recently discharged from hospital with:-
  - Unstable diabetes
  - Significant changes to therapy initiated during admission

Initial GP Work Up

- HbA1C
- Fasting Glucose
- U & C
- Fasting Cholesterol - HDL, LDL, TG
- Urine ACR