

ALFRED HEALTH REFERRAL GUIDELINES: DIABETES

Referral priority guide

Newly diagnosed type 1 diabetes (IDDM)

Newly diagnosed type 2 diabetes (NIDDM)

Recurrent severe hypoglycaemia

Poorly controlled type 1 diabetes (IDDM)

Poorly controlled type 2 diabetes (NIDDM)

Type 1 (IDDM) patients with microalbuminuria or proteinuria

Type 2 (NIDDM) patients with microalbuminuria or proteinuria

Foot ulceration

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<p>Immediate Serious metabolic derangement or diabetes complication that is left untreated would lead to need for hospitalisation, or which requires immediate hospitalisation. Examples:</p> <ul style="list-style-type: none"> • Newly diagnosed Type 1 (IDDM) with or without urinary ketones present • Decompensated Type 1 (IDDM) or Type 2 diabetes (NIDDM) with strongly positive urinary ketones present, dehydration or vomiting • Acutely decompensated Type 1 (IDDM) • Foot ulcer with infection 	<p>Phone Endocrine registrar/Consultant on call if possible on 9076 2000 and/or send to The Alfred Emergency and Trauma Centre</p> <ul style="list-style-type: none"> • Consider urgent referral to The Alfred Emergency & Trauma Centre if suspicion of incipient DKA. • Hospital admission required. <p style="text-align: right;">Return to contents page</p>
<p>Urgent Metabolic deterioration or complication that can be expected to deteriorate rapidly if not attended to. Examples:</p> <ul style="list-style-type: none"> • Acutely decompensated Type 2 (NIDDM) diabetes without clear need for hospitalisation • Newly diagnosed Type 2 diabetes (NIDDM) with blood glucose levels >20mmol/l • Acute foot ulceration without active infection • Pregnancy 	<p>Urgent cases must be discussed with the Endocrinology registrar on call or consultant to obtain appropriate prioritisation and then a referral letter faxed to 9076 6938.</p> <ul style="list-style-type: none"> • Fax referral to Specialist Consulting Clinic on 9076 6938. • Likely to receive an appointment within 1-2 weeks. <p style="text-align: right;">Return to contents page</p>
<p>Soon Diabetes symptoms or complications severely impairing daily functioning or likely to rapidly lead to irreversible deterioration in health Examples:</p> <ul style="list-style-type: none"> • Marked or symptomatic hyperglycaemia not responding to current therapy (ie BGL consistently >15mmol/l) • Recurrent severe hypoglycaemia • Painful neuropathy • Nephropathy with deteriorating renal function • Poorly controlled hypertension • Deteriorating vision • Preconception planning 	<ul style="list-style-type: none"> • Fax Referral to 9076 6938. • Likely to receive an appointment within 2-6 weeks. <p style="text-align: right;">Return to contents page</p>
<p>Intermediate At higher risk of diabetes complications or suffering from a relatively stable chronic complication Examples:</p> <ul style="list-style-type: none"> • Newly diagnosed Type 2 diabetes (NIDDM) without marked or symptomatic hyperglycaemia • Previously diagnosed Type 1 (IDDM) or Type 2 (NIDDM) diabetes with sub-optimal diabetes control (HbA1c>7.0%) • Diabetic nephropathy or microalbuminuria • Peripheral neuropathy or peripheral vascular disease • Dyslipidaemia 	<ul style="list-style-type: none"> • Fax or post letter. • Likely to receive and appointment within 6-12 weeks. <p style="text-align: right;">Return to contents page</p>
<p>Non-urgent • At low risk of rapidly progressive complications of diabetes • Low risk of diabetes complications or less likely to benefit from early specialist review Examples:</p> <ul style="list-style-type: none"> • Well-controlled Type 1 diabetes (IDDM) known to be without current complications • Abnormal glucose tolerance test indicating impaired glucose tolerance only (it is still beneficial for these patients • to receive specific dietary and exercise advice, and to have blood pressure and lipids assessed) • Diagnosed diabetes well controlled on diet alone • Known Type 2 diabetes (NIDDM) with good control and without complications <p>Elderly patients with reasonably well controlled diabetes without complications</p>	<ul style="list-style-type: none"> • Fax or post letter. • Consider periodic specialist review • Appointment may be delayed. <p style="text-align: right;">Return to contents page</p>
<p>Not seen Referrals where the primary problem requiring attention is not directly related to the diabetes and should be directed to another speciality service Examples:</p> <ul style="list-style-type: none"> • Neurological symptoms other than suspected diabetic neuropathies • Chest pain for investigation 	<p>Children under 16 years of age are not seen at the Alfred.</p> <p style="text-align: right;">Return to contents page</p>
<p>Please note: The times to assessment may vary depending on size and staffing of the hospital department. If you are concerned about the delay of the outpatient appointment or if there is any deterioration in the patient's condition, please contact the Endocrine Registrar on call on 9076 2000.</p> <p style="text-align: right;">Return to contents page</p>	

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Evaluation	Management	Referral Guidelines
Newly diagnosed type 1 diabetes (IDDM)		
<p>The important information is the hydration status and presence or absence of ketones</p>	<ul style="list-style-type: none"> If ketones are present, the clinical status of the patient determines urgency Same day arrangements for assessment and care by medical staff of Department of Endocrinology and Diabetes or The Alfred Emergency & Trauma Centre with immediate liaison with diabetes educator will be arranged by the medical team 	<p>Suspicion of incipient diabetic ketoacidosis requires urgent transfer to The Alfred Emergency & Trauma Centre (eg nausea, vomiting, and dehydration). Refer IMMEDIATELY (phone registrar or speak to consultant) or PRIORITY 1.</p> <p style="text-align: right;">Return to contents page</p>
Newly diagnosed type 2 diabetes (NIDDM)		
<p>With blood glucose levels above 15 mmol/l, ketonuria should be checked for and if present manage on the assumption that the patient may be insulin-dependent.</p> <ul style="list-style-type: none"> HbA1c U&Es, Creatinine Liver function tests Lipids Urine Albumin: Creatinine Ratio 	<p>RACGP guidelines for diabetes management in general practice</p>	<p>Refer PRIORITY 1- 2</p> <p style="text-align: right;">Return to contents page</p>
Recurrent severe hypoglycaemia		
<ul style="list-style-type: none"> What insulin regimen is being used? HbA1c U&Es, Creatinine Liver function tests Thyroid function tests Morning cortisol level Urine Albumin: Creatinine Ratio Advise patient to bring blood glucose monitoring book to appointment 	<p>RACGP guidelines for diabetes management in general practice</p>	<p>All patients will benefit from a detailed review involving a diabetes physician, a dietician and a diabetes educator.</p> <p>Refer PRIORITY 1- 2.</p> <p style="text-align: right;">Return to contents page</p>
Poorly controlled type 1 diabetes (IDDM)		
<ul style="list-style-type: none"> What is the insulin regimen? HbA1c U&Es, Creatinine Liver function tests Thyroid function tests Urine Albumin: Creatinine Ratio Advise patient to bring blood glucose monitoring book to appointment Record of eye reviews 		<ul style="list-style-type: none"> All patients will benefit from detailed review by the diabetes multi-disciplinary team and should be referred for physician review. Refer PRIORITY 2. <p style="text-align: right;">Return to contents page</p>
Poorly controlled type 2 diabetes (NIDDM)		
<ul style="list-style-type: none"> Current medications HbA1c U&Es, Creatinine Liver function tests Lipids Urine Albumin: Creatinine Ratio Cardiovascular risk assessment 	<ul style="list-style-type: none"> In addition to glycaemic management: Treat intercurrent illness Manage concomitant cardiovascular risk factors <p>RACGP Diabetes management in general practice</p>	<p>Refer PRIORITY 2- 3, depending on severity.</p> <p style="text-align: right;">Return to contents page</p>

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Evaluation

Management

Referral Guidelines

Type 1 (IDDM) or type 2 (NIDDM) patients with microalbuminuria or proteinuria

- Blood pressure, presence of microvascular or macro vascular complications
- Urine Albumin: Creatinine Ratio and confirmatory 24 hour protein, albumin and creatinine clearance
- HbA1c
- Urine microscopy for cells and casts to help exclude other forms of glomerular disease
- U&Es, Creatinine
- Advise patient to bring blood glucose monitoring book to appointment
- Record of eye reviews
- Blood pressure record

- Treat hypertension aggressively and consider use of ACE inhibitors or A2RB in those who are normotensive
- Optimise diabetes control
- Treat other vascular risk factors

- These patients should be referred for Diabetes Clinic for specialist diabetes care. If the creatinine level is ≥ 200 micromol/L refer to Renal clinic as well.
- Refer PRIORITY 2-3 depending on severity.

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Foot ulceration

- Is the ulcer neuropathic or vascular (or both) in origin?
- Is there active infection?
- Is there invasive infection with spreading cellulitis?
- Is there bony infection? (X-ray and if required bone scan).

[The Alfred Radiology request form](#)

- If suspected, send to The Alfred Emergency & Trauma Centre and phone Endocrinology registrar on 9076 2000.
- Consider wound swab for culture.

- Podiatry treatment to debride and to remove callosities
- Antibiotics if infection
- Stop weight bearing
- Orthotic device
- Revascularisation for peripheral vascular disease

- Patients with invasive infection should be admitted to hospital immediately.
- If patient is systemically unwell, is febrile or has cellulitis, treat as very urgent - send to The Alfred Emergency & Trauma Centre and phone Endocrinology registrar.
- Patients with infected ulcers should be started on appropriate antibiotics after swabbing and be assessed urgently by Podiatry and Diabetes Physician (Refer PRIORITY 1- 2).
- Patients with simple neuropathic ulcers should be referred to the Diabetes Clinic PRIORITY 1- 2.
- Patients with peripheral vascular disease as cause for ulceration should be referred to the Vascular Surgery Clinic for prompt review, as well as the Diabetes Clinic PRIORITY 2).

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