The George Institute for Global Health | Better Health Together – Western Sydney Integrated Health | NSW Government Health – Western Sydney Local Health District

PARTICIPANT REFERRAL FORM

Patient Information OR Patient Label	
*Last name:	Date of birth:
*First name:	Gender: Male ☐ Female ☐
Address:	*Patients mobile number: Other contact number:
Email:	Patients GP:

*Referral Reason	Other Relevant Medical History	Exclusion criteria
☐ Heart disease AND/OR ☐ Type 2 Diabetes (HbA1c 7.1 - 11.4%) ▪ Most recent HbA1c: ___ ___ . ___ %		▪ Any patient unable to provide consent and participate in a clinical trial. ▪ Unable to read text messages in English on their mobile phone.

*Referrer Details	Options to Return Completed Forms
Name: Phone number: Fax number: Email: Address:	**F:** 02 8572 8277 **E:** WSLHD-SupportMe@health.nsw.gov.au **P:** 02 9845 9818
Hospital/department or Practice Name: ☐ Participant self-referred	***Date of referral** ___ / ___ / ____

*Required to be completed.