

PARTICIPANT REFERRAL FORM

SupportMe  **Text messaging support for people with chronic disease**

Patient Information OR Patient Label		
*Last name:	Date of birth:	
*First name:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	
Address:	*Patients mobile number: Other contact number:	
Email:	Patients GP:	
*Referral Reason	Other Relevant Medical History	Exclusion criteria
<input type="checkbox"/> Heart disease AND/OR <input type="checkbox"/> Type 2 Diabetes (HbA1c 7.1 - 11.4%) <input type="checkbox"/> Most recent HbA1c: ____ . ____ %		<input type="checkbox"/> Any patient unable to provide consent and participate in a clinical trial. <input type="checkbox"/> Unable to read text messages in English on their mobile phone.
*Referrer Details		Options to Return Completed Forms
Name:		F: 02 8572 8277
Phone number:		E: WSLHD-SupportMe@health.nsw.gov.au
Fax number:		P: 02 8890 9818
Email:		M: 0404 228 052
Address:		
Hospital/department or Practice Name:		*Date of referral
		___ / ___ / ____
<input type="checkbox"/> Participant self-referred		

*Required to be completed.