

## REQUEST TO ATTEND X-PERT DIABETES PROGRAMME

<b><u>Patient Details</u></b> NHS Number ..... (if known)					
Name: ..... Title: ..... D.O.B.: ..... Gender: .....					
Address: ..... .....					
Post Code: .....			Tel No.: .....		
Have you seen a dietitian before:    Yes / No    If yes, when? .....					
G.P Name: .....					
Address: .....					
<u>Diagnosis of diabetes: (tick relevant box)</u> <input type="checkbox"/> Less than 1 year <input type="checkbox"/> 1-5 years <input type="checkbox"/> 6-10 years <input type="checkbox"/> More than 10 years					
<u>Diabetes Medication</u> ..... .....					
<b><u>Relevant Measurements (optional)</u></b>					
Weight		Height			
For Dietetic use only:                      Date received: .....					

**Please send completed referral to Community Dietetics Dept,  
Riverside Health Centre, Wellington Street, Cardiff, CF11 9SH.**

**For any further information about the X-PERT programme please contact  
Community Nutrition and Dietetic Department at Riverside Health Centre  
on Tel: 20668089.**