

DESMOND Referral Form

Date: Thursday 16th Nov 2017

Venue: Lotteries House, Broome



REFERRER DETAILS	
Referrer Name	
Referring Organisation	
Contact Phone	

CLIENT DETAILS			
Name		DOB	
*Postal Address			
Contact Phone			
Email		NDSS Number	
Are you bringing a support person?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If YES, please state their name

*Diabetes WA will mail a confirmation letter to the client which will include:

- Date, time and location
- A 'Preparing for DESMOND' booklet – including information on what blood results they are required to bring – please complete below

Blood Pressure (Systolic/Diastolic level)	
Total cholesterol level	
LDL Level	
HDL Level	
HbA1c Level (if available)	

Referral forms to be submitted to Boab Health Services

FAX: (08) 9192 7999 or emailed to **reception@boabhealth.com.au**

Partners in Health to Grow Strong, Live Well

Boab Health Services Pty Ltd

Broome Office

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