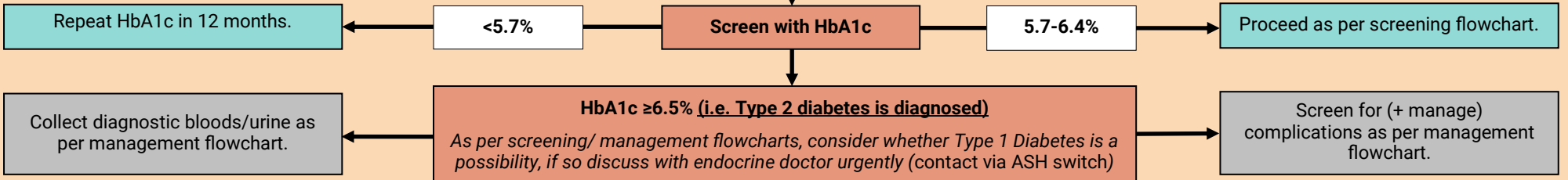


Type 2 diabetes Referral Pathway (aged 17-25 years)

Central Australia Region

Visit with GP / RAN / AHP
May occur in context of:

- Incidental diagnosis when presenting for other reasons
- Symptomatic presentation
- Screening if noted risk factors for T2D (see screening flowchart)
- Annual Health Check



Collaboration between primary health care team, diabetes educators and endocrinologists

- 1) Primary carer (GP, AHP, RAN, NP) start **education about diet + lifestyle + start treatment** as per management flowchart.
 - a) Discern which family members need to be involved RE: diagnosis & treatment plan & invite early.
 - b) Endocrinologists + diabetes educators happy to be involved in these extended discussions to improve "buy in" from the beginning.
 - c) Assess psychosocial factors – consider food security, timing of medications for adherence, sleep patterns, mental health, sexual health, school attendance, family structure, support from other agencies (e.g. youth workers).
- 2) Primary care team to decide on best **referral pathway** depending on circumstances of individual young person. Suggest care under paediatric team if aged 17-18 years and either still at school, cognitive impairment, FASD or behavioural concerns. Suggest care under adult team if aged ≥19 years, or if aged 17-18 years and have left school and no developmental issues.

