

Diabetes and Endocrinology Pregnancy Clinic Referral Form

Centre for Diabetes, Endocrinology and Metabolism

St. Joseph's Hospital, 5th floor

268 Grosvenor Street, London, ON N6A 4V2

Phone: 519-646-6000 ext. 61530 Fax: 519-646-6043

Name: _____ DOB: _____

Address: _____ HC#: _____

PIN#: _____

Phone: _____ Email: _____

Interpreter: No Yes If yes, language: _____

Family Doctor: _____ Fax: _____

Obstetrical Care Provider: _____ Fax: _____

Pharmacy: _____ Fax: _____

G ____ T ____ P ____ A ____ L ____ EDD: _____

Type of Diabetes: GDM _____ (past HX?) _____ Year: _____

Type 1 _____ Type 1 _____ (please include any blood work)

Lab Results for GDM: Fasting: _____ 1hr: _____ 2hr: _____

Was a 50-gram screen done: _____ Results: _____

Guidelines no longer say that > 10.3 is GDM, therefore do OGGTT if 7.8 – 11.0

Other concerns such as Polyhydramnios, large for dates baby, previous pregnancy loss, thyroid

Signature: _____ Date: _____

Name (please print): _____ CPSO#: _____

Phone: _____ Fax: _____

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