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 519-646-6257

Name:_____ DOB: _____

Address:_____ HC#: _____

_____ PIN#: _____

Phone:_____ Email: _____

Interpreter required? ☐ Yes what language? _____

Family Doctor.:_____ Fax: _____

Obstetrical Care Provider:_____ Fax: _____

Pharmacy:_____Fax:_____

G_____T_____P_____A_____L_____ EDD: _____

Reason for Referral:

☐ Gestational Diabetes (GDM) Past History ☐Yes ☐ No Year _____

☐Type 1☐Type 2 If Type 1 or Type 2, please provide recent A1C _____

Lab Results for GDM required for Triage:

If complete results are not provided then referral will be returned with direction to provide missing details. Patients can be triaged from a 75-gram test result.

☐ 50-gram screen done:_____Results:_____

(normal <7.8, **7.8-11.0 patient requires a 75gram 2-hour test**, ≥11.1 diagnostic for gestational diabetes so 75-gram test is not required)

☐ 75-gram results Fasting:_____1 hr:_____2 hr: _____

☐ A1C ≥ 5.7%

☐ random plasma glucose ≥ 11.1 mmol/L

☐ other - please specify: i.e. elevated capillary blood glucose values _____

Signature:_____Date: _____

Name **(please print):**_____OHIP billing #: _____

Phone:_____Fax:_____