DIABETES AND ENDOCRINE PREGNANCY REFERRAL

Fax 519-646-6257

Name:			DOB:	
Address: Phone:			HC#	
Email			PIN#	
Interpreter required? Y ☐ if yes, specify language:				
Family Physician:			Fax:	
Obstetrical Care Provider:			Fax:	
Pharmacy:			Fax:	
G_____T_____P_____A_____L_____			**Estimated Due Date**:	
1. ☐ Gestational Diabetes: Screening				
☐ I authorize the patient's care to be transferred between SJHC and LHSC if pharmacotherapy is warranted, and the patient is aware of the possibility their care may be transferred to SJHC if required.				
☐ 2-STEP APPROACH (50g and 75g) ☐ 1-STEP APPROACH (75g OGTT)				
	Date:	Results:		
50g OGCT		1hr: ☐ Not done		
75g OGTT		Fasting:	1hr:	2hr:
Other: A1c ≥ 5.7% Random plasma glucose ≥ 11.1 mM Elevated capillary BG				
2. ☐ Reason for Referral in Pregnancy				
☐ Type 1 ☐ Type 2 ☐ Prediabetes		Recent A1c (%)		
☐ Other Endocrine (non-diabetes)	Please Specify			
Name:		OHIP Billing #:		Date:
Signature:		Phone:		Fax: