London Health Sciences Centre

St JOSEPH's HEALTH CARE LONDON

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 St. Joseph's and LHSC if pharmacotherapy is warranted and the patient is aware of the possibility their care may be transferred to St. Joseph's 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			
☐ ***Please note: Referring Provider is responsible for prescribing glucometer + supplies prior to patient's intake appointment** (*see example prescription for details*)				
Name:		OHIP Billing #:		Date:
Signature:		Phone:		Fax:

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Referring Provider:
Address:
Phone:
Fax:

DATE:

PRESCRIPTION FOR:

DATE OF BIRTH:

- Glucometer of choice x1
- Capillary blood glucose test strips for glucometer of choice M: 100 strips, repeat x5
- Lancets of choice M: 1 box, repeat x5
- Sharps container x 1

Signature:

CPSO #