Last Name	
First Name	
PHN#	Address
Birthdate *(dd-Mon-yyyy)*	Phone Number

Diabetes In Pregnancy Clinics Referral

Fax completed referral form, prenatal record, relevant lab data, physician consult letters, and recent fetal ultrasound (if applicable) to one of the following sites:

FMC Phone: 403-944-2122 Fax: 403-776-3836
PLC Phone: 403-943-4862 Fax: 403-776-3837
RGH Phone: 403-943-3495 Fax: 403-776-3838
SHC Phone: 403-956-2575 Fax: 403-776-3839

Date *(yyyy-Mon-dd)*

Select Delivery Site
☐ FMC ☐ RGH ☐ PLC ☐ SHC

Referring Physician ______________________ PRACID ______________

Family Physician, if different ______________________ PRACID ______________

Pregnancy Information

LMP *(yyyy-Mon-dd)* ______________ EDC *(yyyy-Mon-dd)* ______________

Patient's email address

Gestational Diabetes Mellitus

Please provide a prescription for home glucose monitoring supplies and provide to patient or return it with your referral (please note, pharmacy may require original prescription)

GDM in a previous pregnancy
☐ Yes ☐ No

Glucose Screen __________ mmol/L

75 g Oral Glucose Tolerance Test
Fasting _________ mmol/L 1 hour _________ mmol/L 2 hour _________ mmol/L

Pre-Existing Diabetes

☐ Type 1
☐ Type 2
☐ IGT/ IFG (pre-diabetes)

☐ Pregnant
☐ Pre-Conception

Date of Diagnosis *(yyyy-Mon-dd)* ______________

Hgb A1C _____ % Date *(yyyy-Mon-dd)* ______________

Current Medications

____

____

Factors that may affect learning

☐ Language other than English *(indicate primary)*
☐ ______________________________
☐ Psychological
☐ Economic
☐ Physical limitations
☐ Other ____

Note
Referring Physician assumes continued medical care for diabetes in pregnancy until patient is assessed by Endocrinologist, as per clinic protocol. For patients with pre-existing diabetes, family physician will be informed of plan for postpartum diabetes care.

Other Physician Comments / Orders

Physician's signature	Date *(yyyy-Mon-dd)*	Pager or contact number

100553(Rev2017-05)