NORTH YORK GENERAL
Making a World of Difference

Diabetes Education Centre
GESTATIONAL DIABETES MELLITUS OF PREGNANCY REFERRAL

FORM SF0281 **Page 1 of 1** **Rev. 05/2020**

Patient LABEL / Identification Area

UNIT E7, 2 CHAMPAGNE DRIVE, TORONTO, ON, M3J 0K2 **TEL:416-756-6923 FAX: 416-756-6329**

Patient name: _____

Address: _____

_____DOB: _____

Family Physician:_____ HCN: _____

Home #: _____

Work #: _____

Cell #: _____

Email: _____

SIGNIFICANT MEDICAL HISTORY:

☐ Thyroid ☐ Hypertension ☐ Dyslipidemia ☐ Family history of diabetes

GESTATIONAL HISTORY:

Gravida_____ Para_____ Currently at _____weeks GA; EDC_____

Previous GDM_____ ☐ Spontaneous pregnancy ☐ Assisted reproduction pregnancy

LAB DATA/ ☐ attached

GESTATIONAL

50 gm Glucose Screen: 1 hr_____ at _____weeks GA

75 gm OGTT: FBS_____ 1hr _____ 2hr_____at _____weeks GA

MEDICATIONS/ VITAMINS:

The patient will be seen by a multidisciplinary team.
Your signature authorizes the dietitian to alter meal plan as required and the nurse to administer and adjust diabetes medication according to the medical directive approved by North York General Hospital.
Summary/ progress reports will be sent. Patients are advised to have a 75 gm OGTT within 6 months after delivery through their family physician.

☐ Endocrinology consult at Diabetes Education Centre's discretion: Billing Number _____

_____
Referring Physician Signature

Date:

Name, mailing address,
Telephone & fax:
(please print or stamp clearly)

Send additional reports to:

DATE	TIME (24 h)	SIGNATURE	PRINT NAME

Approved By: DEC Forms Committee Approval Date: 05/2020(archive: N/A)