



**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: _____

Home #: _____

Address: _____

Work #: _____

_____ DOB: _____

Cell #: _____

Family Physician: _____ HCN: _____

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