Humber River Hospital
Lighting New Ways in Healthcare™

DIABETES IN PREGNANCY CLINIC REFERRAL FORM

Diabetes Education Centre
(located on 1st floor at the Healthy Living Clinic)
1235 Wilson Ave.
Toronto, ON, M3M 0B2
Tel: 416-242-1000 ext. 23400
Fax: 416-242-1058

Patient Information- Please complete:					
Name:			H #:		
Date of Birth (dd-mm-yy)			OHIP #:		
Address:	Apt#:		City:	Province:	Postal Code
Phone number (Home): ( )			Phone number (Work): ( )		ext:
Does the patient speak English? ☐ Yes ☐ No (Language Spoken):					
Is the patient planning to deliver at Humber River Hospital ☐ Yes ☐ No					
Any reason why the patient should NOT be in a group class? ☐ Yes ☐ No Reason:					
Can we leave a message? ☐ Yes ☐ No					
Maternal Age:	LMP:	EDD:	Gestational age (weeks):	G:	P:
☐ Antenatal records attached **AND/OR** ☐ Other relevant records attached					

TYPE OF DIABETES

- ☐ Gestational/Date:_____
  - ☐ A1c (only if before 24 weeks gestation): _____
  - ☐ Fasting BG (only if before 24 weeks gestation): _____
  - ☐ 50g OGGT result:_____
  - ☐ 75g OGTT result: FBG:____ 1hr:____2hr:____
    - ☐ 2-step ☐ 1-step
- ☐ Pre-existing DM- please refer as early in pregnancy as possible
  - ☐ Type 1- Duration:_____ A1c:_____ Date:_____
  - ☐ Type 2- Duration:_____A1c:____ Date:_____
  - ☐ Prediabetes (IGT/IFG)
    Duration:_____ A1c:_____ Date:_____

CURRENT MEDICATIONS

☐ Prenatal Vitamin
☐ Oral hypoglycemic agents
Type and dose:
_____
_____
☐ Insulin –Type and Dose:
_____
_____
☐ Other:
_____

COMPLICATIONS

☐ Hypertension ☐ Nephropathy ☐ Neuropathy
☐ Retinopathy ☐ Dyslipidemia

MEDICAL HISTORY

☐ Previous GDM ☐ PCOS
☐ Depression ☐ Other: _____

Referring Physician/Nurse Practitioner Information	**Primary Care Provider Information**
Name: OHIP billing #:	Name: OHIP billing #:
Tel no: ( ) Fax: ( )	Tel no: ( ) Fax: ( )
Signature:	

FOR OFFICE USE ONLY

☐ Book for class Monday:_____
☐ Book direct to clinic & Endocrinologist:_____
☐ Patient notified on (dd-mm-yyyy): _____