St. Joseph's Healthcare Hamilton

Gestational Diabetes Care and Education

100 West 5th Street, Hamilton, Ontario
Medical Outpatient Department, Level 0, Block C, Reception D
Phone: (905) 522-1155 Ext.32045 / Fax: (905) 521-6128

Referral Form

Date of Request: _____

Referring Physician Contact Information

Name: _____
Address: _____
Phone: _____
Fax: _____

Patient Name: _____
Last **First** **Middle**

Address: _____ **City:** _____ **Postal Code:** _____

Phone (Home): (_____) _____ **Phone (Cell): (_____)** _____

DOB: _____ **Age:** _____ **Sex:** _____ **Weight:**_____ **kg/ lbs**
YYYY MM DD

HIN: _____ **Version:** _____

Reason for Referral:

☐ **Gestational Diabetes Mellitus** *first diagnosis in pregnancy*

☐ **T2DM: pregnant with pre-gestational diabetes**

☐ **Pre-conception pregnancy planning for T2DM**

Please note T1DM and pregnant or high risk T2DM (i.e. A1C>9%)

needs to go to MUMC and will not be seen at our clinic

IMPORTANT: ***PLEASE SPECIFY ANY SPECIAL NEEDS***

Language/communication barriers? ☐ **NO** ☐ **YES**

Specify: _____

Other: _____

If indicated, an individual appointment will be scheduled instead of class due to interpretation needs.

Gestational Age (# of weeks):

_____

Due Date:

_____

☐ **Previous GDM** _____
year

Co-morbid Conditions

☐ **Mental health diagnosis**
☐ **Heart disease**
☐ **Hypertension**
☐ **Renal impairment/Proteinuria**
☐ **Pregnancy Complications:**_____
☐ **Other:** _____

Current Medications/supplements:

LABS:

☐ **50g OGTT: 1hr**_____
If between 7.8-11, send for 75 gram OGTT before referring

☐ **75g OGTT: FBS**_____
1hr_____ **2hr**_____

Mandatory for T2DM, not required for GDM

☐ **Recent HbA1c(within 2 months):**_____

Date:_____

Comments/other pertinent history:

_____

_____

Requesting Physician: X _____ **Specialty:** _____

Signature: X _____ **OHIP Billing #:** _____

Family Physician: _____ ****If referred by a midwife a GP's signature is required****