



**DIABETES IN
PREGNANCY REFERRAL**

PHONE: (604) 875-3135
FAX: (604) 875-3041

Date of referral: ____/____/____
DD / Mth / YEAR

SURNAME		FIRST NAME	
PERMANENT ADDRESS			
POSTAL CODE	CELL PHONE	HOME PHONE	WORK PHONE
DATE OF BIRTH DD/Mth/YEAR		AGE	
PHN			

OK for BC Women's Hospital to contact patient? YES NO

Is patient aware of her diagnosis of diabetes? YES NO

Interpreter required Y N (see reverse) Language: _____

Referring MD/Midwife: _____ MSP Billing #: _____

Phone: _____ FAX: _____

***Indication for referral: (**will be returned if incomplete**)** **MRSA Positive**

check all that apply

- | | | |
|--|---|--|
| <input type="checkbox"/> Gestational DM | <input type="checkbox"/> Pre-Diabetes (IFG/IGT/HbA1C) | <input type="checkbox"/> Asymmetrical Macrosomia |
| <input type="checkbox"/> Type 1 Diabetes Mellitus (DM) | <input type="checkbox"/> Pre-Pregnancy Counselling | <input type="checkbox"/> Polyhydramnios |
| <input type="checkbox"/> Type 2 DM | <input type="checkbox"/> Transfer of Care | <input type="checkbox"/> Other _____ |

Comments: _____

G T P SA T A L LNMP ____/____/____ **EDD** ____/____/____ **GA:** _____
DD / Mth / YEAR DD / Mth / YEAR (at date of referral)

Provider Requested:

- No preference Dr. D. Thompson Dr. J Kong

***Please attach following documents:**

- Antenatal Record 1 & 2 (if pregnant)
 Bloodwork/Labs ***Diabetes results must be included**
 Ultrasound or Diagnostic Reports

Received BCW:

-

Hospital of Delivery BCW Other

FOR BC WOMEN'S OFFICE USE ONLY:

RN/RD Appointment: ____/____/____
DD / Mth / YEAR Time

MD Appointment: ____/____/____
DD / Mth / YEAR Time

Physician: _____

Reviewed by: _____
Date: _____

- Referring office Notified
 Patient Notified
 Cerner

Key: (abbreviations)

EDD = expected date of delivery	HbA1C = hemoglobin A1C	PHN = Personal Health Care Card Number
FBG = fasting blood glucose	IFG = impaired fasting glucose	RD = Registered Dietitian
GTT = glucose tolerance test	IGT = impaired glucose tolerance	RN = Registered Nurse

Provincial Language Service Interpretation criteria:

- Patient will be asked to sign **Informed Consent** for treatment/procedure and patient is not fully fluent in English
- Patient has little or no English skills and has no family/friend to translate for them during clinical encounter

Provincial Language Service does not come without significant cost.

If your patient has basic English language skills and can manage her appointment that does not include consent, diagnosis or treatment, please do not request an interpreter.

All information and medical terminology is explained in simple English so the use of an interpreter is not necessary for most appointment types. Should we determine that there is in fact a need, we will access interpretation support via telephone which is an effective modality for interpreting health care as indicated in the most recent literature and current best practices.

Thank you for your cooperation and support.

Maternity Ambulatory Program
BC Women's Hospital & Health Centre