BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority

# 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 | | | |

**Registered to deliver at BCWH**

☐ YES - **Please complete referral in its entirety**
☐ NO - **Please apply for Diabetes in pregnancy care in patient's own or nearest community (*unless registered to deliver in Sechelt Hospital)***

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

**Email Address:** _____

**Is patient aware of their diagnosis of diabetes?** ☐ YES ☐ NO

**Interpreter required?** ☐ YES ☐ NO (See reverse) **Language:** _____

**Referring MD/Midwife:** _____ **MSP Billing #:** _____

**Phone:** _____ **FAX:** _____

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

*check all that apply*

☐ Gestational DM
☐ Type 1 DM
☐ Type 2 DM
☐ Transfer of Care (must be registered to deliver at BCWH)

Comments: (please provide any additional information that will be helpful to this person's care, such as history of mental health challenge or eating disorder)

_____
_____
_____
_____

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

***Please attach following documents: (*referrals will not be processed until supporting documentation is received*)**

☐Antenatal Record 1 & 2
☐Bloodwork/Labs ***Diabetes results must be included**
☐Ultrasound or Diagnostic Reports

***If patient was seen in this service during a previous pregnancy, who was their endocrinologist.**

☐ Dr. Thompson ☐ Dr. Kong

**Key:** (abbreviations)
EDD = expected date of delivery
DM= Diabetes Mellitus
MD= Medical Doctor
MRSA= Methicillin-resistant Staphylococcus Aureus
LNMP= Last known Menstrual Period


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**Provincial Language Service Interpretation criteria:**

☐ Patient will be asked to sign **Informed Consent** for treatment/procedure and patient is not fully fluent in English

To maintain the accuracy, confidentiality, and professionalism of clinical communication, friends or family members are not permitted to act as interpreters.

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 are 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

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