Waitemata District Health Board
Best Care for Everyone

Maternity Service

First Name: _____ **Gender:** _____
Surname: _____
[***AFFIX PATIENT LABEL HERE***]
Date of Birth: _____ **NHI#:** _____
Ward/Clinic: _____ **Consultant:** _____

Diabetes in Pregnancy Referral

Referrer details	
Referral date:	Mobile:
LMC/Referrer (Print name):	FAX:

Pregnancy details			
G: P:	EDD:	Gestation:	☐ By scan ☐ By dates Include copies of any scans
Height:	Booking weight:	BMI:	
HBA1c date: Result:	Polycose date: Result:	GTT date: Result: /	
Interpreter required: ☐ No ☐ Yes Language:			

Risk factors	Significant Obstetric/Medical history
☐ Previous GDM ☐ Age 40 or over ☐ BMI 35 or over ☐ Previous LGA baby ☐ Previous stillbirth ☐ Two first degree relatives with diabetes ☐ Polycystic ovarian syndrome ☐ Antipsychotic medication ☐ Prednisone	

Plan:		
☐ Appointment Date:	☐ Appointment not required	☐ Letter sent GP/LMC/Woman
☐ OGTT 24-26 weeks		

Triaged by (*print name*):	Designation:
Date:	

Diabetes in Pregnancy Referral