Waitemata District Health Board
Best Care for Everyone

First Name: _____
Surname: _____
Contact no: _____
Address: _____
Date of Birth: _____ **NHI#:** _____

Maternity Service

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