Island Health

Diabetes in Pregnancy Referral

VGH

Patient Information		
First Name:	Last Name:	Date of Birth (ddMmmyyyy)
PHN	MRN *(Optional)*:	Primary Phone #:
Email:	Special Instructions:	

Provider Information		
Referring Provider:	MSP #:	☐ Locum
Phone#:	Fax#:	
Primary Care Provider:	☐ Same as ordering provider	Copy to (full name):

Reason for Referral

☐ Type 1 ☐ Type 2 ☐ GDM ☐ RD Only

☐ Endo Only ☐ Preconception ☐ Other: _____

EDC (dd/Mmm/yyyy): **Weeks Pregnant:** **G:** **P:**

Diabetes in last Pregnancy: ☐ Yes ☐ No **Previous LGA Infant**: ☐ Yes ☐ No

For Type 1 or 2 A1C:	Date:	
1 hr GTT (50gms):	Result:	Date:
2 hr GTT (75 gms):	FBS Result:	Date:
	1 Hour:	Date:
	2 Hour:	Date:

Comments:

Barriers to Group Learning:

☐ Language Barrier ☐ Visual Impairment ☐ Cognitive Deficit

☐ Unstable Mental Health Issues: ☐ Hearing Impairment ☐ Other *(specify)*:

_____ _____

Provider Signature **Date**

ROUTING	
If Pregnant- Please attach Antenatal Records.	
Fax Completed form to: 250-727-4168	Office Phone: 250-727-4266
OFFICE USE ONLY	
Date Received:	Appointment Type:
Date Triaged:	Initials:

If you have questions or would like to suggest changes to this form, please contact RegionalClinicalForms@islandhealth.ca