fraserhealth

DIABETES AND PREGNANCY CLINIC REFERRAL

PLEASE COMPLETE IN FULL AND PRINT CLEARLY

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☐ **JPOCSC** 9750 140th Street, Surrey, BC
Phone: (604) 582-4558 Ext 763993 Fax: (604) 582-3775

☐ **ARH** 32900 Marshall Road, Abbotsford, BC
Phone: (604) 851-4700 Ext 646348 Fax: (604) 851-4813

Patient's Full Legal Name: _____
Last First Middle

Other Name(s) (if applicable): _____

Personal Health Number: _____ **Date of Birth:** ____/____/____ *(DD, MM, YYYY)*

Address: _____ _____
Street City Province Postal Code

Home Phone: _____ Cell Phone: _____

*Interpreter Required: ☐ No ☐ Yes Language: _____

Insurance Type: ☐ MSP ☐ WCB ☐ Out-of-Province ☐ Self-Pay Other: _____ RCMP or Armed Forces #: _____

G T P SA TA L	**Multiple Gestation:** ☐ Yes ☐ No ☐ Twins ☐ Triplets ☐ Other
LMP: (DD/MM/YY) Circle which is the final EDC **EDC by LMP:** (DD/MM/YY) **EDC by U/S** (DD/MM/YY)	☐ Gestational Diabetes ☐ Idiopathic Macrosomia ☐ Pregnant Type 1 Diabetes ☐ High Risk Diabetes in Pregnancy ☐ Pregnant Type 2 Diabetes ☐ Preconceptual ☐ Other: _____
Additional Comments: (e.g. if patient is not appropriate for group education, phone patient directly, etc.)	**Diabetes Medications:** ☐ Not applicable ☐ Metformin ☐ Other: _____ ☐ Insulin Type: _____ Dose: _____ Type: _____ Dose: _____

IMPORTANT: PLEASE ENSURE THE FOLLOWING ARE ATTACHED (to avoid delays)

☐ 2 Hr GTT
☐ A1c (within 3 months in T1DM, T2DM)
☐ Antenatal Record Part I and Part II (If started)
☐ All relevant medical reports/labs related to maternal diagnosis, T1DM, T2DM, and/or high obstetric risk

Family Physician (if different from referring source)
Name: _____
MSP #: _____
Phone: _____ Fax: _____
☐ Patient has no GP/NP

Referring Health Care Provider
Name: _____
MSP #: _____
Phone: _____ Fax: _____
☐ GP ☐ Prenatal Clinic ☐ CBP __ NP __ RM
☐ OB/GYN ☐ MFM ☐ Other: _____

For DAP use only: ☐ Missing lab work (GTT or A1c) request made on _____ (date)
☐ Interpreter needed _____ 1½ hour for 1:1) ☐ Interpreter Booked
☐ Class & Dr. ☐ Regular (7-1 0 days) ☐ Urgent (within 3 business days) ☐ Punjabi Class
Do not book 1:1 during class time
☐ 1:1 Clinician & Doctor (☐ Same day ☐ 1 week later ☐ Urgent)
☐ Preconceptual (☐ Same day ☐ 1 week later)
☐ Pump 1:1 Clinician & Doctor (☐ Preconceptual ☐ Pregnant)

DAP Appointment:
☐ Class ☐ 1:1
Date: ____/____/____ (DD, MM,YYYY)
Time: _____
☐ Follow-Up
Date: ____/____/____ (DD, MM, YYYY)
Time: _____

Referring Practitioner Signature: _____ Date of Referral: _____

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