Sunnybrook
WOMEN & BABIES PROGRAM

# Diabetes in Pregnancy Clinic Referral Form

2075 Bayview Avenue, M-Wing, 4th floor
Toronto, Ontario M4N 3M5
Phone: (416) 480-5367
Fax: (416) 480-5616

**ALL INFORMATION MUST BE PROVIDED OR REFERRAL WILL BE SENT BACK**

**Patient Information** (Please complete this section **or** stamp with bradma)

Name: _____ HFN#: _____
First Name Last Name

Date of Birth: _____ OHIP# _____
mm/dd/yyyy

Address: _____ Phone (home): (___) ___-____
Street Apt. No

_____ Phone (work): (___) ___-____
City Province Postal Code

Is patient planning to deliver at Sunnybrook? ☐ Yes ☐ No
Is there any reason patient should NOT be in a group class ☐ Yes (specify reason) _____

Maternal age ____ LMP _____ EDD _____ Gestational Age _____ weeks G___ P ___

☐ Antenatal Records Attached **OR** ☐ Patient Records in OBTV

**Type of Diabetes (DM)**

☐ Gestational/Date _____
- ☐ A1c (only if before 24 weeks gestation) _____
- ☐ Fasting BG (only if before 24 weeks gestation) _____
- ☐ 50g OGCT result: _____
- ☐ 75g OGTT result: FBG____1hr _____ 2hr _____
  - ☐ 2 step ☐ 1 step

☐ Pre-existing DM – please refer as early in pregnancy as possible
- ☐ Type 1; Duration _____ A1c _____ Date _____
- ☐ Type 2; Duration _____ A1c _____ Date _____
- ☐ Prediabetes (IGT/IFG); Duration _____ A1c _____ Date _____

**Current Medications**

☐ Prenatal Vitamin
☐ Oral hypoglycemic agents
Type and Dose _____
_____
_____
☐ Insulin
Type and Dose _____
_____
_____
☐ Other _____
_____

**Complications**

☐ Hypertension ☐ Nephropathy ☐ Neuropathy
☐ Retinopathy ☐ Dyslipidemia

**Medical History**

☐ Depression ☐ PCOS
☐ Previous GDM
☐ Other _____

**Referring Physician / Midwife / Nurse Practitioner Information**

Name _____ OHIP Billing #: _____
Phone (___) ___-____ Fax (___) ___-____

Signature _____ Date _____

**Primary Care Provider Information**

Name _____
Phone (___) ___-____
Fax (___) ___-____

**For Office Use Only**

☐ Book for class Tuesday _____ ☐ Folder ☐ Binder
☐ Book direct to clinic _____
Patient notified on _____ OR _____