Gestational Diabetes Referral Form

Use Ball Point Pen Only

208– D Foust St, Asheboro NC 27203 Phone: (336) 625-9400

Patient Information

Name: _____ DOB: __/___/____ Phone: _____

Address: _____

Insurance: _____ Ht: _____ Wt: ____

Due Date: _____

Diagnosis

☐ O24.419 Gestational DM, antepartum

☐ O24.919 Gestational DM with pregnancy

☐ O24.414 Gestational DM requiring insulin

☐ O24.410 Gestational DM diet controlled

☐ Other, ICD-10 code _____

	100-gram oral glucose load	75-gram oral glucose load
Reference Ranges	**Patient Results**	**Patient Results**
95 mg/dl		
180 mg/dl		
155 mg/dl		
140 mg/dl		

☐ **Meal Planning Only 1-2 hour session**

Dietitian to determine meal plan unless MD specifies

☐ Calorie level_____

Follow-up Visit(s) 1/2 hour-1 hour

- Review of glucose records
- Review of food logs and meal planning
- Meal planning adjustments as warranted
- Assess for problems and concerns
- Future risk of diabetes for mother and child
- Reduce the future risk of diabetes
- Symptoms and diagnostic criteria for diabetes

Plan of Care for Gestational Diabetes

☐ **Initial Visit: 1-2 hours**

- Assessment
- GDM diagnosis criteria
- Optimal glucose levels
- GDM risk to baby
- Meal planning
- Effects of exercise
- Monitoring
- Hypoglycemia treatment
- Future considerations

☐ **Medical Nutritional Therapy**

Dietitian to determine meal plan unless MD specifies

☐ Calorie level _____

☐ **Glucometer Instruction**

Unless otherwise prescribed, monitoring will be fasting and 2 hours postprandial.

Fasting goal:

☐ <95 mg/dl (default) ☐ Other_____mg/dl

2-hour postprandial goal:

☐ <120 mg/dl (default) ☐ Other_____mg/dl

☐ **Insulin Instruction (1-2 hr session)**

- Insulin type _____
- Dosage _____ Time_____

☐ Pen ☐ Syringe

Provider Information

Provider: _____

*** Signature:** _____

Date: __/___/___

Phone: _____

Primary Care Provider: _____

PLEASE ATTACH A COPY OF PATIENT'S INSURANCE CARD

Please fax completed form to **Randolph Health Diabetes Center at (336)-625-9500**

Randolph Health