

FNQ Diabetes in Pregnancy Referral for Education and/or Clinical Register

Please note that this information will be included on the FNQ DIP Clinical Register unless we are advised otherwise. The register has been approved by the Human Research Ethics Committee and verbal consent is required from the woman or if < 16 years of age, parent or guardian must also give verbal consent, prior to making this referral. (See NT & FNQ Diabetes in Pregnancy Clinical Register Information for Women: <http://www.dipp.org.au/>)

Please send completed form to:
 Email: DIPPINQ@menzies.edu.au or
 Fax: 07 3169 4250

Yes <input type="checkbox"/>	The woman agrees to have her information sent to the FNQ DIP Clinical Register (if < 16 years of age parent or guardian must also agree)	Date of Referral ____/____/____					
<input type="checkbox"/>	The woman was unable to be contacted.	Date ____/____/____					
No <input type="checkbox"/>	The woman DOES NOT want to be included in the Clinical Register, please note in her clinic records						
Name/ Contact Details							
Surname:		First name:					
Date of Birth:		URN:					
Address:							
Phone and /or Email:		Medicare #:					
Ethnicity							
<input type="checkbox"/>	(1) Aboriginal (2) Torres Strait Islander (3) Aboriginal and TSI (4) Caucasian (5) Indian Subcontinent (6) Arab/Middle East	(7) Chinese (8) Vietnamese (9) Maori (10) Pacific Islander (11) Other ethnic groups	(12) Filipino (13) African (14) Non-Indigenous not otherwise specified				
Information at date of Referral							
Pre-existing Hypertension	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Gravida	Parity			
Information from First Trimester (or earliest date)							
Alcohol	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Quit <input type="checkbox"/>	Smoking	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Quit <input type="checkbox"/>
Height cms	Pre-pregnancy weight		Weight 1st available		Weight on referral		
	kgs		kgs		kgs		
	Date Self reported <input type="checkbox"/>		Date		Date		

Surname:				URN:			
Diabetes Information- at date of referral							
Diabetes Type		<input type="checkbox"/> Type 1		<input type="checkbox"/> Type 2		<input type="checkbox"/> GDM	
Known GDM in a previous pregnancy				<input type="checkbox"/> No		<input type="checkbox"/> Yes	
If Type 2, time since diagnosis		<input type="checkbox"/> 0-5 years		<input type="checkbox"/> 5-10 years		<input type="checkbox"/> >10 years	
Medication- first trimester							
Metformin	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date commenced / /	Insulin	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date commenced / /
Screening results -for current pregnancy							
Date of First Ultrasound		Gestational age at ultrasound		Gestational Age (at referral)		EDB from U/S	
/ /		wks .		wks		/ /	
75gm Oral Glucose Tolerance Test (OGTT) result for diagnosis							
Date: / /		Fasting: mmol/L		1hr: mmol/L		2hr: mmol/L	
Early 75gm Oral Glucose Tolerance Test (OGTT) result (if within normal range)							
Date: / /		Fasting: mmol/L		1hr: mmol/L		2hr: mmol/L	
Other Glucose Screening for diagnosis							
Date / /		<input type="checkbox"/> Fasting mmol/L		<input type="checkbox"/> Random mmol/L		<input type="checkbox"/> HbA1c %	
Pre-pregnancy	Date	Result	1 st Trimester	Date	Result		
Creatinine		umol/L	Creatinine		umol/L		
Urine ACR		g/mol	Urine ACR		g/mol		
Hb		g/L	Hb		g/L		
HbA1c		%	HbA1c		%		
Referral Details							
Name of Current Clinic / GP Practice (where to contact for follow up care):				Doctor/GP name:			
Other Clinics Patient Attends:							

Pre-pregnancy = up to 3 mths before conception