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

Please note that this information will be included on the NT 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 Diabetes in Pregnancy Clinical Register Information for Women: http://www.dipp.org.au/)

Send completed form to Email: DIPClinicalRegister.THS@nt.gov.au

Fax: 8922 6740 ------Top End

Fax: 8951 6996 -----Central Australia

Yes ☐	The woman agrees to have her information sent to the NT DIP Clinical Register (if < 16 years of age parent or guardian must also agree)	Date of Referral ______/________/________
No ☐	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:						HRN:					
Address:											
Phone and /or Email:											
Medicare Number											

Ethnicity			
☐	(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) Unknown but not Aboriginal or Torres Strait Islander

Information at date of Referral				
Hypertension	No ☐	Yes ☐	Gravida	Parity

Information from First Trimester (earliest date)		
Height . cms	**1st available** Weight . kgs	Date of Weight / /

Alcohol	No ☐	Yes ☐	Quit ☐	Smoking	No ☐	Yes ☐	Quit ☐

Surname:	HRN:

Diabetes Information- at date of referral

Diabetes Type ☐ Type 1 ☐ Type 2 ☐ GDM

Known GDM in a previous pregnancy ☐ No ☐ Yes

Medication- at referral

	No	Yes		No	Yes
Metformin	☐	☐	Insulin	☐	☐

Home blood Glucose monitoring- at referral

	No	Yes
Currently	☐	☐

Screening results -for current pregnancy

Date of First Ultrasound	Gestational age at ultrasound	EDB from U/S
/ /	. wks	/ /

75gm Oral Glucose Tolerance Test (OGTT) result

Date: / / Fasting: mmol/L 1hr: mmol/L 2hr: mmol/L

Other Glucose Screening

Date
/ / ☐ Fasting ☐ Random mmol/L

**

Pre-pregnancy (up to 3 mths before conception)	Date	Result	1st Trimester (up to 13 weeks)	Date	Result
Creatinine		umol/L	Creatinine		umol/L
Urine ACR		g/mol	Urine ACR		g/mol
Hb		g/L	Hb (first antenatal visit)		g/L
HbA1c		%	HbA1c		%

Referral Details

Current Clinic / GP of pt:

Other clinics pt attends: