menzies
school of health research

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NT Diabetes in Pregnancy Clinical Register
Registration form

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. If < 16 years of age, a parent or guardian must 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: DIPClinicalRegister.THS@nt.gov.au or*
Fax: 08 8922 6740 – Top End *Fax: 08 8951 6996 – Central Australia*

Yes ☐	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 ______/________/______
☐	The woman was unable to be approached.	Date ______/________/______
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 #	

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) Non-Indigenous not otherwise specified

Information from first trimester (or earliest date)

Pre-existing Hypertension	No ☐	Yes ☐	Gravida	Parity
Alcohol	No ☐ Yes ☐ Quit ☐		Smoking	No ☐ Yes ☐ Quit ☐
Height cms	Pregnancy weight 1st available: kgs Date			

NT Diabetes in Pregnancy – Registration form

Surname:	HRN:

Diabetes in pregnancy type

Diabetes Type ☐ Type 1 ☐ Type 2 ☐ GDM

Known GDM in a previous pregnancy ☐ No ☐ Yes

If Type 2, indicate year diagnosed (if available):

Medication first trimester

Metformin	No ☐	Yes ☐	Insulin	No ☐	Yes ☐	Date commenced or earliest recorded / /

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 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/

Other Glucose Screening for diagnosis

Date: / / ☐ Fasting mmol/L ☐ Random mmol/L ☐ HbA1c %

Pre-pregnancy*	Date	Result	1st 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: (will be clinic/practice which receives post-partum list for follow-up care)
Other Clinic Patient attends: (if applicable)

*Pre-pregnancy = up to 3 mths before conception