Women's Health
Maternity Diabetes Service Referral

SURNAME: ____________________ NHI: __________

FIRST NAMES: ____________________

DATE OF BIRTH: ____ / ____ / ____ SEX: __________

Please attach patient label here

MATERNITY DIABETES SERVICE REFERRAL

DATE OF REFERRAL: ______________

LMC / Referrer and Address	Patient Address
	Patient Telephone Home Work Mobile
LMC / Referrer Contact Details Phone Fax Email If IMW will you remain LMC? Yes / No	Interpreter Yes / No Language
Reason for referral / provisional diagnosis	LMP EDD (USS confirmed) Gravida ______ `Para ______ BMI ______
Referral discussed with (if applicable)	
Relevant Obstetric History / Medical History	GDM Screening Date ______ Date ______ Polycose ______ GTT Fasting ______ 2 Hour ______
	Can you please start the Woman BG testing Yes / No
	Please Enclose: Booking Information ☐ Obstetric History ☐ Include Attached: All Bloods ☐ All Scans ☐ **NB** Please arrange growth scan if scan not done in last 4 weeks ☐

Please complete all the details so Maternity Diabetes Team can process the referrals as soon as possible.
Fax: 375 7080 For ADVICE phone: 021 410 995

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