AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Women's Health
Maternity Diabetes Service Referral

MUST ATTACH PATIENT LABEL HERE

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct visit patient label

DATE OF REFERRAL: _____

LMC / Referrer and Address

LMC / Referrer Contact Details

Include your mobile if you want a text acknowledging receipt of referral

Phone
Fax
Email

If IMW will you remain LMC? Yes / No

Reason for referral / provisional diagnosis

Referral discussed with (if applicable)

Relevant Obstetric History / Medical History

Patient Address

Patient Telephone

Home
Work
Mobile
Email *(If happy to be contacted this way)*

Interpreter Yes / No

Language

LMP

EDD (USS confirmed)

Gravida _____ Para _____

Booking BMI _____

Current weight _____

GDM Screening

Date _____ Date _____

Polycose _____ GTT Fasting _____

HbA1c _____ 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 ☐

PROOF B

MATERNITY DIABETES SERVICE REFERRAL

CR2949

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