menzies
school of health research

Postal: PO Box 41096, Casuarina NT 0811, Australia
Location: John Mathews Building (Bldg 58),
Royal Darwin Hospital Campus, Rocklands Drv, Casuarina NT 0810
Ph: (08) 8946 8600 Fax: (08) 8946 8464
Website: menzies.edu.au
ABN: 70 413 542 847

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 ☐	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 ______/________/______
☐	The woman was unable to be contacted.	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:	URN:						
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 at date of Referral				
Pre-existing Hypertension	No ☐	Yes ☐	Gravida	Parity

Information from First Trimester (or earliest date)							
Alcohol	No ☐	Yes ☐	Quit ☐	Smoking	No ☐	Yes ☐	Quit ☐

Height cms	Pre-pregnancy weight kgs	Weight 1st available kgs	Weight on referral kgs
	Date Self reported ☐	Date	Date

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Surname:	URN:

Diabetes Information- at date of referral

Diabetes Type	☐ Type 1	☐ Type 2	☐ GDM
Known GDM in a previous pregnancy		☐ No	☐ Yes
If Type 2, time since diagnosis	☐ 0-5 years	☐ 5-10 years	☐ >10 years

Medication- first trimester

Metformin	No ☐	Yes ☐	Date commenced / /	Insulin	No ☐	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
/ / ☐ 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 (where to contact for follow up care):	Doctor/GP name:
Other Clinics Patient Attends:	

Pre-pregnancy = up to 3 mths before conception