600 University Avenue
Toronto, Ontario, Canada M5G 1X5

MS 855 **Front** (Rev. 01.2018) Page 1 of 1

Clearly imprint patient identification card

Gestational Diabetes Referral Form

Referring Source: **Referral Date:** ____________________ (YYYY MM DD)

- ❑ **MSH Obstetrician** ❑ **Family Physician** ❑ **Midwives Collective of Toronto**
- ❑ **External Obstetrician** ❑ **External Endocrinologist** ❑ **Other** ____________________

Referring physician's first and last name: ____________________ Signature: ____________________

Billing #: ____________________ Phone: ____________________ Fax: ____________________

RN / Admin's contact name, phone#, email: ____________________

Indicate Endocrinologist:

❑ **Dr. Denice Feig**
Tel: (416) 586-8590 Fax: (416) 361-2657

❑ **Dr. Diane Donat**
Tel: (416) 340-3592 Fax: (416) 340-3314

Patient Information *(please fill out if not an MSH OB referral):*

Patient's first and last name: ____________________

Phone: ____________________ Date of Birth: (YYYY MM DD) ____________________

Health Card #: ____________________ Version __________ MRN: ____________________

Does patient need interpreter services? ❑ No ❑ Yes If Yes, please specify: ____________________

Has the patient received diabetes education from RN or RD during this pregnancy? ❑ No ❑ Yes

Is the patient on: ❑ Insulin? ❑ Metformin?

Is the patient currently testing with a glucose meter? ❑ No ❑ Yes

Patient's current gestational age is: ______________ EDC: ______________

Is baby's weight greater than 90th centile? ❑ No ❑ Yes ❑ Unknown

Additional concerns: ____________________

____

G.C.T.: _______ Date: __________ (YYYY MM DD)

O.G.T.T.: _____ Date: __________ (YYYY MM DD)

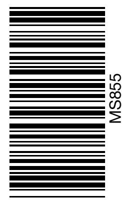
FBS: ____________________

1HR: ____________________

2HR: ____________________

Must be Faxed with this referral form:

❑ *Page 1 of Ontario Prenatal Record 1*



For Office Use Only

To Be Completed by Endocrinologist Office: referral faxed to

❑ ***MSH FHT*** / ❑ ***Taddle Creek FHT Date:*** __________ (YYYY MM DD)

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