WakeMed

Pregnancy and Diabetes Program
Phone: 919-350-4589   Fax: 919-350-4585

WakeMed Raleigh Campus
3000 New Bern Avenue
Raleigh, NC 27610

WakeMed Cary Hospital
1900 Kildaire Farm Road
Cary, NC 27518

Physician Order Form

I am referring the following patient for medically necessary gestational diabetes self-management education.

Patient Information (complete information or place patient sticker here)

Name: ______________________________

MR# ____________________ DOB: ______________

Home phone: ____________________

Other phone: ____________________

Home address: ____________________

____

EDC: ____________ Pre-gestational Weight: __________ Current Weight: __________ Height: ________

Insurance/Health Plan ____________________ Insurance ID# ____________________

S.S.# ____________________ Language (circle): English Spanish Other: __________

Diagnosis—please check appropriate diagnosis code

	☐ Gestational Diabetes Mellitus (648.83)	☐ Type 1/Pregnant (648.03)
	☐ Impaired Glucose Tolerance (648.83)	☐ Type 2/Pregnant (648.03)

Screening Results: 3 Hour OGTT/O'Sullivan

Based on ACOG practice bulletin, a positive diagnosis is defined as two or more plasma glucose values at or above one of the following criteria:

	Carpenter/Coustan	NDDG	Patient Results: 3 hr OGTT	Patient Results: O'Sullivan
Fasting	95 mg/dl	105 mg/dl	________	
1 hour	180 mg/dl	190 mg/dl	________	________
2 hour	155 mg/dl	165 mg/dl	________	
3 hour	140 mg/dl	145 mg/dl	________	

Patient Plan of Care

☑ **Assessment**

☑ **Gestational Diabetes Education--**includes

- Risk of GDM for mother & baby
- Personal risk for GDM
- Blood glucose monitoring
- Effects of exercise
- Meal planning

One week follow up:

- Assess for problems/concerns
- Review of meal plan & guidelines
- Review of plasma glucose records

☑ **Medical Nutrition Therapy (MNT) for GDM**

Unless otherwise prescribed, dietitian to determine calories   ☐ Calorie Level ______________

☑ **Frequency of BG Monitoring During Pregnancy:** (check preferred)

- ☐ Fasting (<95 mg/dl)
- ☐ 1 hour post-prandial (<140 mg/dl **or** ________)
- ☐ 2 hour post-prandial (<120 mg/dl **or** ________)
- ☐ Pre-prandial
- ☐ Bedtime
- ☐ 0300

☐ **Initiate Insulin Therapy:** When MNT fails to achieve optimal glucose control, medical management is recommended.

	Type	Amount	Time
Basal Insulin			
Bolus Insulin			

☑ **In case of hypoglycemia, follow outpatient pregnancy hypoglycemia treatment plan.**

Physician Signature ____________________ **Date** __________ **Phone** ____________

Please fax completed form to #919-350-4585