

Date of Referral _____

Gestational Diabetes Education Prescription

FAX TO: (757) 312-6271 CRH Outpatient Scheduling

Patient Name _____

Home Phone # _____

Mobile Phone # _____

DOB _____

Healthkeepers Auth. # (if applicable) _____

DIAGNOSIS:

Gestational Diabetes (ICD 10 code O24.4)

Other: _____

SUPPORTING LABS:

OGTT Fasting _____ 1 Hour _____ 2 Hour _____ 3 Hour _____

Gestational Diabetes Consult/Class:

Includes:

Nutrition management and blood glucose monitoring

1.5 to 2 hours of counseling with dietitian and diabetes educator

Comments: _____

Print Name of Referring Provider _____ Phone _____

Group Name, Address and Fax: _____

Physician's/Provider's Signature _____ Date _____

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If you have any questions please call Central Registration at (757) 312-6137 or Lifestyle Center at (757) 312-6132.