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**DIABETES LIFECARE - PLAN OF CARE
 (FOR PREGNANT PATIENTS ONLY)**

85 Jefferson Street, (Room 113), Hartford, CT 06102 • Office: 860-545-3526; Fax: 860-545-3184

PATIENT INFORMATION				
Patient's Name:				
Address:				
Home Phone:		Work Phone:		Other Contact Phone:
Insurance Plan:				
Date of Birth:		Due Date:		
Pre-Pregnancy Weight:		Current Weight:		Height:
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:(please specify):				
Medications/Supplementation:				
Test Date:		1-Hour 50 gm Result:		
Test Date:		3-Hr 100 gm Results : FBS:		1 Hr: 2 Hr: 3 Hr:

DIAGNOSIS	
<input type="checkbox"/> Gestational Diabetes	<input type="checkbox"/> Type 2 Diabetes:
<input type="checkbox"/> Type 1 Diabetes	<input type="checkbox"/> Other Pertinent Medical Conditions:

* **Check either box #1 or box #2:** (You may only select one option.)

<input type="checkbox"/> 1. I recommend that Diabetes LifeCare choose the Plan of Care for my patient. (Stop here and sign below if you checked box 1) <input type="checkbox"/> 2. I have chosen the Plan of Care and will control overall management of GDM for my patient. (Please check the box for the type of referral desired, Group or Individual and then sign below.)
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PLEASE INDICATE REFERRAL FOR:

Gestational Diabetes (GD) Group Class
 (2 or more people)

Individual Session
 (for a patient with special needs)

* **Must check box for each desired topic below**

Gestational Diabetes (GD) Class: 3 hours	
GD overview	½ hour
Self Glucose Monitoring	½ hour
Complications and Exercise	½ hour
Meal Planning	½ hour
Healthy Food Choices	½ hour
Carbohydrate Counting	½ hour

Individual Gestational Diabetes Topics		
GD overview	½ hour	<input type="checkbox"/>
Self Glucose Monitoring	½ hour	<input type="checkbox"/>
Complications and Exercise	½ hour	<input type="checkbox"/>
Insulin Management	2 hours	<input type="checkbox"/>
Nutritional Management	2 hours	<input type="checkbox"/>

Print Provider Name: _____ Phone Number: _____

Provider Signature: _____ Fax Number: _____

DLC Provider Signature: _____ Date/Time: _____