Hartford Hospital
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571780

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

85 Seymour Street, (Suite 725), Hartford, CT 06106 • Office: 860-972-3526; Fax: 860-545-3184

PATIENT INFORMATION				
Patient's Name:				
Address:				
Home Phone:	Work Phone:	Other Contact Phone:		
***Insurance Plan:**		***ID Number #:**		
Date of Birth:	Due Date:			
Pre-Pregnancy Weight:	Current Weight:	Height:		
Language: ❑ English ❑ Spanish ❑ 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	
❑ 024.911,099.910 Gestational Diabetes	❑ E11.9 Type 2 Diabetes
❑ E10.9 Type 1 Diabetes	❑ Other

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

❑ 1. I recommend that Diabetes LifeCare choose the Plan of Care for my patient.
(Stop here and sign below if you checked box 1)

……

❑ 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.)

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	❑
Self Glucose Monitoring	½ hour	❑
Complications and Exercise	½ hour	❑
Insulin Management	2 hours	❑
Nutritional Management	2 hours	❑

Print Provider Name:_____ Phone Number:_____

Provider Signature:_____ Fax Number:_____

Date:_____ Time:_____