CHESAPEAKE REGIONAL HEALTHCARE
LIFESTYLE & WELLNESS

American Diabetes Association. *The American Diabetes Association Recognizes this education service as meeting the National Standards for Diabetes Self-Management Education.

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 _____

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