LUTON & DUNSTABLE UNIVERSITY HOSPITAL

| D | D | M | M | M | 2 | 0 | Y | Y |
|---|---|---|---|---|---|---|---|---|
| Example 1 | 5 | S | E | P | 2 | 0 | 1 | 2 |

# REQUEST FOR GTT SCREENING FOR GESTATIONAL DIABETES

## PREVIOUS GESTATIONAL DIABETES (Identified at booking)

☐ Previous Gestational Diabetes
☐ Refer to M. Sweeney / R. Trepiccone (do not make any appts).
EDD .....
Name of midwife …….. Signature ……..
Date
Completed form to M. Sweeney / R. Trepiccone

## GTT CRITERIA RISK ASSESSMENT (Undertaken at 16 weeks)

**Risk Factor referral form**
Tick appropriate box/s below

☐ BMI: ↑ 30 at booking
☐ Previous baby > 4.5kgs
☐ First degree relative with diabetes
☐ Family origin
☐ South Asian, Black Caribbean, Middle Eastern

EDD ……. Date when pregnancy is 24 weeks ……..
Preferred clinic venue ……..

Midwife completing form..... Signature…….
(Print name)
Date form completed.....

## CLERICAL STAFF ONLY

Clinic appointment to be made between 24 -26 weeks gestation
Venue ……
Date…….. Time ……..
Booked in IPM Y/N
Written GTT information / appointment sent to woman ☐
Date……..

When completed, file in maternity notes.

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| | D | D | | M | M | M | | 2 | 0 | Y | Y |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Example | 1 | 5 | | S | E | P | | 2 | 0 | 1 | 2 |