Women's Medicine Collaborative*
A Lifespan Partner
BY WOMEN. FOR WOMEN.®

146 West River Street
Providence, RI 02904
Third Floor ~ Suite 11D
Fax: 401-793-7988
WomensMedicine.org

OB Medicine: 401-793-7410
Back Line for Physician Office Use:
401-793-7485

Diabetes in Pregnancy Program

Welcome to the Women's Medicine Collaborative Diabetes in Pregnancy Program. We hope to provide your patients with the tools and encouragement needed to achieve a safe pregnancy and healthy baby. The Program is designed to address the needs of the individual patient and to complement the degree of involvement you desire in your patient's diabetes care. Please choose the resources that you wish for your patient from the list below. Our first consultation letter will provide an opportunity to modify your request as appropriate. An appointment can be made immediately via our direct phone line (401-793-7485), or we can call your patient, as you wish.

Please contact us with questions or concerns at any time:

Lucia Larson, MD **Pager 401-350-9743**

Please fax form along with prenatal intake pages 1-4, recent blood sugars, lab results and other pertinent records to: 401-793-7988. Thank you.

Urgency of Consult: ○ Within 24-48 hours ○ Within 1-2 weeks ○ Routine Appointment

Gestational age on date of request: _____ Weeks _____ Days EDC: _____ /_____ / _____

Diabetes type: ○ Type 1 ○ Type 2 ○ Gestational Diabetes

Present diabetes treatment: ○ No treatment ○ Diet only ○ Glyburide ○ Metformin ○ Insulin

Translator needed? ○ No ○ Yes - Preferred Language: Spoken _____ Written _____

Services requested - This information is required for us to book your patient's appointment. Please select what you would like for your patient (check all that apply).

- ○ No OB Medicine physician involvement
- ○ One-time consultation by OB Medicine physician
- ○ Co-management of diabetes during pregnancy and postpartum by OB Medicine physician
- ○ Nutrition counseling by dietician
- ○ Diabetes education by nurse
- ○ Glucose meter instruction by nurse
- ○ Insulin injection instruction by nurse

DATE OF REQUEST_____/_____/_____

PATIENT _____ DOB _____ /_____ / _____

ADDRESS _____

_____

PHONE Home _____ Cell _____ Work _____

May we leave a message stating the call is from "Women's Medicine Collaborative" or "Dr. ____'s office"? ○ Yes ○ No

PRIMARY INSURANCE _____ ID# _____

SECONDARY INSURANCE _____ ID# _____

REFERRING PROVIDER _____ PHONE _____ FAX _____

*The Miriam Hospital d.b.a. Women's Medicine Collaborative