North Alabama CommunityCare

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Gestational Diabetes Referral Form

Patient Name: _____

Medicaid Number: _____

Date of Birth: _____/_____/_____

Address: _____

Phone Number:_____

Due Date: _____/_____/_____

Diagnosis:

☐ Gestational Diabetes (ICD 10 code O24.4)

☐ Other: _____

Supporting Labs:
GTT Fasting _____ 1 Hour_____2 Hour_____ 3 Hour _____

After receiving initial nutritional counseling with a registered dietitian with the local hospital Diabetes Education Center, the patient will be referred for follow-up nutritional counseling with NACC's Registered Dietitian.

Form Completion

Print Name of Referring Provider: _____

Provider Telephone Number: _____

Provider Signature:_____

*****Upon completion, please fax to NACC at 256-382-2715.*****