Please keep in mind, that we need a new „Überweisungsschein“ (Transfer form from your gynecologist) every new quartile

Gestationsdiabetes-Bogen

Diabetologische Schwerpunktpraxis
Dr. Jürgen Neumaier
Dr. Julia Klee
Fachärzte für Innere Medizin
Diabetologen

Given name / Family Name:____________________

date of birth: _______________

eMail Address: _______________________

Phone:______________Mobile No:____________

Gynecologist:______________________

Approximated date of delivery: _____________

previous pregnancies / number of children (years of birth /weight at birth)?______________________

abnormalities in this pregnancy Yes □ No □ Results of Glucosetesting at Gyn.? ____/_____/____

previous gestational diabetes? Yes □ No □ When?_______ Insulin therapy? Yes □ No □

History:

Height (m) ……….. weight **before** pregnancy (kg)………

weight now (kg) ………

own birthweight.........

Is there Diabetes in your family (parents, grandparents, siblings, aunts, uncles…) Yes □ No □

if yes, in whom ____

Do you suffer from?

□ arterial hypertension □ high cholesterol

□ Allergies Yes □ No □ , if yes, which: _____________________

□ other diseases or preconditions:___________________________

Medication (Dose) ?

1.______________________ 4.______________________

2.______________________ 5.______________________

3.______________________ 6.______________________

Medication allergies? Yes □ No □ if yes, which:____________________________________

Ist this precondition in your family?

□ arterial hypertension □ high cholesterol □ Gout □ cardial infarction □ Stroke

Do you smoke?

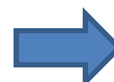
□ yes, how much per day? _____ □ No

if yes, at what age did you start smoking? ____________

Do you drink alcohol?

□ yes, how much and what per day?_______ □ No

Please see backside!



<u>Are you enruled at your GP in the „hausarztzentrierten Versorgung (HzV)“ ?</u>

□ yes □ no

Consent to transfer data/medical information

My data can be given by Dr. Neumaier/Fr. Dr. Klee to other persons.

□ No □ yes, whom (for example husband etc, name)? ________________________

_________ ___________________________________

Date Name in Letters + Signature

Consent to collect and transfer patient data to Lab an health insurance etc. for financial accounting etc./

Consent to transmit data including medical report to gynecologist

Declaration of consent to the collection/transmission of patient data in accordance with § 73 Paragraph 1 b SGB V

I ____ agree

(First name, family name, date of birth)

- that my treating doctor transmits my treatment data and findings to my gynecologist for the purpose of documentation to be kept by the family doctor and further treatment.
- that the doctor treating me collects the treatment data and findings required for my treatment from my gynecologist or other doctors or service providers and processes and uses them for the purposes of the medical services to be provided by my treating doctor.

My gynecologist is: ____

My family doctor is: ____

I am aware that I can revoke this declaration in whole or in part at any time for the future.

____

(place, date) (Signature of the patient or legal representative)

Note: My treating doctor may not transmit, process and use my treatment data and findings for purposes other than those mentioned above.