Patient Care Orders—Postpartum Management of Diabetes in Pregnancy

Diet

☐ Discontinue IV when drinking well
☐ Regular Diet, no added sugar

Glucose Monitoring:

☐ For women with diet controlled gestational diabetes (GDM) or < 30 u of TDD insulin:
  ☐ No monitoring required
☐ For women with GDM and > 30 u TDD insulin or Type 2 diabetes:
  ☐ ac meals and hs until discharged
☐ For women with Type 1 diabetes:
  ☐ ac meals and hs until discharged
  ☐ allow patient to self-manage glucose monitoring and insulin administration/adjustment
☐ For women on insulin pump:
  ☐ Self-management of glucose monitoring and insulin titration according to Policy and Procedure—Use of Continuous Subcutaneous Insulin Infusion Pumps in Hospitalized Patients

Glucose Management:

☐ For women with GDM and > 30 u TDD insulin or Type 2 diabetes:
  ☐ Lantus or Levemir: ________ @ hs
  ☐ Rapid insulin (Humalog or Novorapid): ________ ac each meal
☐ For women with Type 1 diabetes: (suggest starting dose 0.3u/kg pre-pregnancy weight)
  ☐ Basalbolus therapy—to calculate TDD see TABLE 1
  ☐ Lantus or Levemir: ________@hs (40% of TDD)
  ☐ Rapid insulin (Humalog or Novorapid): ______ ac meals (60% of TDD ÷3 meals)
☐ Insulin pump therapy: (suggest 60% of pre-pregnancy rate)
  ☐ Basal rate: ____________________________
  ☐ Insulin:Carbohydrate Ratio: ________________
  ☐ Correction Factor: ______________________

Discharge Instructions:

☐ Advise patient to:
  o Arrange follow-up appointment with Diabetes Specialist _____weeks after discharge
  o Arrange follow-up appointment with Diabetes Education Program 6 to 8 weeks after discharge
  o Schedule 75 OGTT 6 weeks to 6 months post-delivery for women with GDM
  o Continue to follow pregnancy meal-plan and continue prenatal vitamins
☐ Fax responsible Diabetes Specialist, Primary Care Provider and Diabetes Education Program notification of patient’s discharge, including weight of baby and mode of delivery.  (NB. This line to be tailored accordingly per organization’s procedures/EMR capability)

Date: ____________________________  Physician Signature: ______________________________
Fax #: ____________________________
Your signature indicates that checked bulleted items are authorized orders.