Birmingham Women's NHS
NHS Foundation Trust

Gestational Diabetes, Diagnosis and Management

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Name of Lead Officer	Nina Johns
Name of originator/author:	Michelle Barratt, Julie Murphy, Nina Johns
Job title of author:	Midwife
Target audience:	All staff in the Maternity Directorate

Version Control Sheet

Version	Date	Author	Status	Description of Amendment
1.0	27th September 2007	T. Johnston J. Webber T. Smyth R. Hemming	Archived	New guideline
2.0	20th January 2012	M. Barrat J. Murphy N Johns	Approved	

Contents

1. Introduction

Gestational Diabetes Mellitus (GDM) is defined as any degree of glucose intolerance with onset or first recognition during pregnancy regardless of whether diet modification alone or insulin in addition is used to treat and without excluding the possibility that glucose intolerance may have preceded the pregnancy.

GDM has been reported in 1-14% of pregnancies.

Women with GDM have a significant risk of developing Type 2 diabetes (50% in 10 years postpartum) (NICE 2008).

GDM is associated with:

- Fetal macrosomia (defined as fetal weight >90th centile or >4000g), and an increase risk of shoulder dystocia.
- Increased risk of induction of labour, or caesarean section.
- It is also associated with transient neonatal hypoglycaemia, obesity and/or diabetes later in the baby's life. (NICE 2008).

Good glycaemic control throughout pregnancy reduces these risks but will not eliminate them.

2. Objectives

This clinical guideline aims to provide evidence based recommendations for the screening and management of gestational diabetes. These recommendations include guidance on:

- Screening criteria for gestational diabetes mellitus
- Interpretation of oral glucose tolerance test (GTT) results
- Management of gestational diabetes – referral process to appropriate clinic
- Glycaemic control
- The timetable of antenatal appointments to be offered to women with gestational diabetes
- Timing and mode of birth
- Intrapartum and postpartum care of women with gestational diabetes
- Neonatal care of babies born to gestational diabetic women

Further to these recommendations, this guideline will provide the basis for working to optimise outcomes for women with gestational diabetes and to achieve similar outcomes to non-diabetic pregnant women.

3. Policy Scope

This guideline applies to all antenatal women booked for care at Birmingham Women's NHS Foundation Trust who are at risk of gestational diabetes.

4. Indemnity Statement

The Trust will generally assume vicarious liability for the acts of its staff, including those on honorary contract. However, it is incumbent on staff to ensure that they:

- Have undergone any suitable training identified as necessary under the terms of this policy or otherwise
- Have been fully authorised by their line manager and their Directorate to undertake the activity
- Fully comply with the terms of any relevant Trust policies at all times
- Only depart from any relevant Trust guidelines providing that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible clinician, it is fully appropriate and justifiable. Such decisions are to be fully recorded in the patient notes.

5. Definitions

Gestational Diabetes is any degree of glucose intolerance with its onset (or first diagnosis) during pregnancy and usually resolving shortly after delivery.

6. Duties and Responsibilities

6.1 Obstetrician

- Document previous medical and obstetric history
- Provide individual management plan for pregnancy and post natal period in hand held notes
- To communicate to the woman the details of the likely timetable of antenatal appointments, including maternal and fetal assessments
- To communicate to the woman the risks of gestational diabetes to her and her pregnancy and confirm the targets for glycaemic control
- Discuss and record in notes management plan for delivery and post natal period
- Arrange ultrasound scans (USS) to monitor fetal growth and wellbeing
- To Discuss the timing and mode of birth (including induction of labour, caesarean section, analgesia and anaesthesia) and offer Induction of Labour (IOL) at 38-39 weeks if on metformin/insulin or evidence of fetal macrosomia on ultrasound scan
- Book admission date with either Ward 1 or Delivery Suite if delivery or induction is indicated, and provide woman with contact details.
- Review maternal and fetal observations during process of induction and ensure individual plan of care is made (to include maternal assessment, fetal assessment, treatment required, frequency of investigations and timing of next review) and documented in the medical notes.

6.2 Diabetes Specialist Midwife (DSM)

- Provide verbal and written information about GDM: what it is and implications in pregnancy
- Initiate routine antenatal care alongside diabetes management
- Refer to Joint Diabetes Clinic if requires hypoglycaemic agents or if obstetric complications arise
- Provide contact number for support between clinic visits
- Discuss individual management plan for pregnancy and post natal period
- Review home blood glucose monitoring
- Arrange ultrasound scans to monitor fetal growth and wellbeing

- If diet controlled offer stretch and sweep at 38 and 39 weeks and Induction of Labour at 40 weeks
- Book admission date on Ward 1 if induction is indicated, and provide woman with contact details.

6.3 Diabetes Physician / Diabetes Specialist Nurse (DSN)

- Give education on home blood glucose monitoring and provide equipment
- Advising women treated with insulin of the risks of hypoglycaemia and hyperglycaemia unawareness in pregnancy
- To communicate with the woman the targets for glycaemic control
- Review home blood glucose monitoring
- Review and discuss insulin regimen or metformin doses
- Make changes to medications for diabetes during pregnancy
- Advise on the importance of lifestyle changes to reduce the risk of developing type 2 diabetes for both the woman and her baby in later life.

6.4 Dietician

- Assess and advise on diet, lifestyle and physical activity
- Agree plan of care.

6.5 Midwifery Assistants

- Perform oral GTT and refer all results to DSM or Diabetes Team
- Check BP and urinalysis.

7. Procedures

7.1 Screening

Women who have had previous GDM are at significant risk of developing GDM in future pregnancies. The reoccurrence rate is 30-84% but if they were treated with insulin it is 75% (Scott et al 2002, NICE 2008). Therefore women with a history of GDM should have a 75g Oral GTT at 16-18 weeks and if normal, it should be repeated at 24-28 weeks.

The following criteria put patients into a high risk category for developing diabetes and therefore a 75g Oral GTT should be performed at 24-28 weeks (unless specified):

- First degree relative (parent or sibling of the pregnant women)
- Previous baby >4500g or >95th centile
- Previous unexplained stillbirth
- Body Mass Index (BMI) >30kg/m^2
- Ethnic origin:- South Asia (India, Pakistan, Bangladesh), Black Caribbean or Middle East (Saudi Arabia, United Arab Emirates, Iraq, Jordan, Syria, Oman, Qatar, Kuwait, Lebanon, Egypt)
- History of Polycystic Ovary Syndrome
- On oral steroids (usually Prednisolone) in pregnancy
- On Tacrolimus in pregnancy

- 2+ glycosuria on two or more occasions or ≥ 3+glycosuria on one occassion an urgent GTT should be arranged
- Polyhydramnious AND Fetal macrosomia >4000g or >95th centile
  - an urgent GTT should be arranged
- Individualised cases may be discussed with the diabetic / obstetric team and an individualised plan of care can be arranged e.g if random blood glucose >7.2.

When risk factors develop after 36 weeks, contact the Diabetes Specialist Midwife. Women identified after 35+6/40 should be offered education about the risk of gestational diabetes. Arrange for a random blood glucose and if result is ≥6.0mmol/L, the woman should be offered blood glucose monitoring, referred to the GDM clinic and advised on dietary changes for 1-2 weeks.

7.2 Interpretation of Oral Glucose Tolerance Test (GTT) results

Interpretation of 75g Oral GTT (Venous plasma glucose)

75g Oral GTT	Fasting		120 min
Normal	<6.1	and	<7.8
Diabetes	=>7.0	or	=>11.1
Impaired Glucose Tolerance	<7.0	and	=>7.8
Impaired Fasting Glucose	=>6.1<7.0	and	<7.8

Interpretation of 75g Oral GTT (Capillary Plasma glucose)

75g Oral GTT	Fasting		120 min
Normal	<6.1	and	<8.9
Diabetes	=>7.0	or	=>12.2
Impaired Glucose Tolerance	<7.0	and	=>8.9
Impaired Fasting Glucose	=>6.1<7.0	and	<8.9

If result is abnormal or impaired discuss with Diabetes Specialist Midwife and refer to GDM clinic on Friday mornings.

7.3 Management of Women with GDM

- All newly diagnosed women are to be seen in GDM clinic on Friday mornings. They will be seen by the Diabetes Specialist Midwife (DSM), +/- Diabetes Specialist Nurse (DSN) and a Dietician. (see appendix D)
- At the first clinic appointment women are to be seen by Diabetes Specialist Midwife who will explain about GDM and the implications in pregnancy. They should also be seen by the Diabetes Specialist Nurse (DSN) to be educated regarding performing home blood glucose monitoring and a Dietician for review of existing dietary and lifestyle habits and advice regarding a diabetic diet/healthy eating in pregnancy.
- Women will be seen in the GDM clinic the following Friday, to review home blood glucose monitoring (HBGM). If blood glucose readings are controlled on diet alone, women will be seen every two weeks in the GDM clinic.
- If women require hypoglycaemic agents (insulin or metformin) or develop obstetric complications they will be referred to the Diabetes Clinic managed by Consultant Diabetologist and Consultant Obstetrician (lead for diabetes) on Tuesday mornings. These women should receive intensive specialist care by the multi-disciplinary team (MDT: consultant obstetrician and consultant

diabetologist, dietician, midwife and diabetic specialist nurse) in the joint diabetes antenatal clinic, supported by the Selly Oak Diabetes Centre
- NB. Some women will require hypoglycaemic agents immediately and therefore will be referred immediately to the Diabetes Clinic.

7.4 Blood Glucose Control

Aim is to achieve normal HBGM values without significant hypoglycaemia. There is evidence that high blood glucose levels in pregnancy are associated with macrosomia and fetal morbidity, particularly high postprandial levels (NICE 2008). Targets levels for capillary glucose are:

- Fasting & pre-meals 3.5-5.9mmol/l
- 1 hour post prandial <7.8mmol/l

Monitoring blood glucose:

- Women with GDM should be encouraged to test fasting blood glucose levels (before each meal and before bedtime) and 1 hour after meals
- Urine will be tested for ketones at each antenatal visit

Hypoglycaemia

Women treated with insulin should be advised of the risks of hypoglycaemia in pregnancy. Nausea and vomiting can also contribute to hypoglycaemia. Women and their immediate family should be given information on recognition of the symptoms of low blood glucose levels and how to treat hypoglycaemia in relation to their current treatment whether this is diet or hypoglycaemic agents. Women treated with insulin should receive instruction on the use of concentrated glucose solutions.

Hyperglycaemia

Women with GDM should be advised on the prevention of hyperglycaemia through diet. Women treated with insulin who become unwell or have persistent vomiting should be advised to check blood glucose every 2-4 hours and omit quick acting insulin if not eating and contact DSN/DSM.

7.5 Treatment of GDM

The treatment of GDM, through diet, monitoring and, if necessary, insulin therapy, reduces the rates of PET, depression, large birth weight babies, shoulder dystocia and caesarean section rates (Crowther et al 2005, Landon et al 2009). NICE (2008) recommend women with GDM receive treatment but this may be through diet and exercise alone. Dietary advice, including eating carbohydrates with a low glycaemic index, helps reduce postprandial blood glucose and improve overall glycaemic control. With diet alone, 82-93% of women can achieve glycaemic targets. Also regular exercise can lower fasting and postprandial blood glucose and may reduce the need for insulin (NICE 2008).

Hypoglycaemic agents should be commenced if blood glucose control does not meet target ranges after 1-2 weeks on a controlled diet. Hypoglycaemic agents (Insulin or metformin) should be tailored depending on glycaemic control and acceptability of the individual woman. In addition, if evidence of fetal macrosomia, e.g. If the fetal

abdominal circumference is >70th centile on USS, hypoglycaemic agents should be considered in the presence of borderline HBGM values.

7.6 Monitoring Fetal Growth and Wellbeing

Women with GDM are at increased risk of having a baby with macrosomia, with increased risks of shoulder dystocia, brachial plexus injury, prolonged labour, operative delivery and postpartum haemorrhage. In addition, women with GDM and raised BMI are also at risk of undiagnosed small for gestational age (SGA) babies. Therefore women with GDM should be offered:

- Serial ultrasound monitoring of fetal growth and liquor volume every 4 weeks from 28 to 36 weeks
- Increased ultrasound monitoring in the presence of intrauterine growth restriction. Additional routine monitoring of fetal wellbeing before 38 weeks is not recommended in women with GDM unless there is a risk of intrauterine growth restriction, hypertension or Pre-eclampsia (PET).
- In pregnancies with these other risk factors, umbilical artery doppler ultrasound has a better diagnostic accuracy than fetal cardiotocography (CTG). These women should be reviewed weekly following ultrasound examination of liquor volume and Doppler and the need for induction of labour discussed.

7.7 Criteria for Identifying the High Risk Patient and Those Requiring Transfer from Midwifery-led GDM Care to Consultant-led GDM Care

- Women requiring treatment other than diet i.e commencement of Metformin or Insulin
- Obstetric complications such as PET, Antepartum haemorrhage (APH)
- Previous poor obstetric history
- Abnormal fetal ultrasound growth profile
- Booked under consultant lead care prior to diagnosis of GDM for ongoing obstetric or medical conditions
- Those women in whom blood glucose control worsens despite appropriate intervention
- Recurrent lack of attendance at antenatal appointments
- Reduced fetal movements
- Pre-meal glucose levels ≥10mmol/L

These women should be seen in the joint Diabetes Clinic and discussed with the MDT during clinic for an ongoing plan of care and considered for hospital admission for fetal monitoring and improvement of blood glucose control.

7.8 Corticosteroids for Suspected Preterm Delivery

- If delivery is suspected or indicated before 34+6 weeks gestation, administration of corticosteroids should be considered to prevent neonatal respiratory distress syndrome
- If steroids are given to women who have GDM which is treated with insulin, intravenous insulin according to a sliding scale should be given to prevent severe hyperglycaemia and fetal distress (see Guideline for Sliding Scale

Insulin Following Antenatal Administration of Betamethasone to Diabetic Women).

- If steroids are given to women who have GDM which is treated with diet or metformin, blood glucose levels should be monitored hourly and if two consecutive readings of more than 7.8mmol/L discuss with the diabetic team.
- Obstetric Consultant lead for Diabetes, or on call Obstetric Consultant, must be consulted prior to any decision to treat.

7.9 Plan for Delivery

A plan for delivery should be discussed with the woman at the first appointment in GDM clinic. Women seen in the GDM clinic and who remain on diet treatment alone with predicted fetal growth in the normal range; will be offered a stretch and sweep at 38 and 39 weeks and offered induction of labour at 40 weeks. Women seen in the Joint Diabetes clinic on metformin or insulin, or with predicted fetal macrosomia, will be offered induction of labour at 38-39 weeks gestation.

Additional routine monitoring of fetal wellbeing before 38 weeks is not recommended in women with GDM unless there is a risk of intrauterine growth restriction, hypertension or Pre-eclampsia (PET), or change in results of blood glucose monitoring or reduced fetal movements.

In pregnancies with these other risk factors, umbilical artery doppler ultrasound has a better diagnostic accuracy than fetal cardiotocography (CTG). These women should be reviewed weekly following ultrasound examination of liquor volume and Doppler and the need for induction of labour discussed.

7.10 Communication

- All pregnant women should be encouraged to take control of their care and enjoy their pregnancy
- Members of the MDT should work in partnership with women
- Women should be involved in decisions about their care and offered the opportunity to make informed choices through the provision of appropriate information

7.11 Schedule and Content of Antenatal Appointments

As GDM can be diagnosed at various stages of pregnancy, the timing and content of antenatal care appointments varies depending upon when the diagnosis was made. However antenatal appointments should follow the schedule and content for routine antenatal care recommended in the NICE (2005) antenatal care guidelines. Additional antenatal visits may be required to monitor and improve glycaemic control for individual women.

Women who receive hypoglycaemic agents should be seen in the joint Diabetic Clinic and therefore follow the schedule of antenatal care appointments recommended in the Guideline for Preconception Care and Antenatal Management of Women with Pre-existing Type 1 or Type 2 Diabetes.

7.12 Intrapartum Care

Women on insulin therapy should commence an insulin sliding scale during labour as per the management of Type I and Type II diabetics. Women treated during the pregnancy with diet or metformin should monitor capillary blood glucose levels hourly. If the blood glucose is more than 7mmol/l then repeat 1 hour later. If the blood glucose is more than 7mmol/l on two consecutive occasions then the sliding scale insulin regime should be started (as per Type I diabetes). All women with gestational diabetes should have continuous electronic fetal heart rate monitoring in labour.

7.13 Postpartum Care

- Insulin and metformin in women with GDM should be stopped immediately following delivery. Women should be advised to monitor blood glucose levels for 24 hours.
- Women should be given advice regarding diet, exercise and weight control. They should be informed of the risk of developing Type 2 diabetes or GDM in future pregnancies and therefore should be given advice regarding the signs of hyperglycaemia.
- An Oral GTT should be performed 6 weeks postnatally. Women should be advised of the importance of attending this appointment and given a leaflet with details of what to do prior to the test. If the result is normal the woman should be advised to have a fasting plasma glucose test annually.
- Contraception advice should also be given.

7.14 Care of the Baby Born to the Woman with GDM

Women with GDM should be advised to initiate skin to skin if possible and feed within 30 mins after delivery. Babies should have pre-feed blood glucose monitoring commencing prior to their second feed (Refer to Babies at risk of Hypoglycaemia).

8. Review, Monitoring, and Revision Arrangements

All Trust policies / guidelines will be monitored for compliance in one of three ways:

- **Review** is normally proactive and designed to evaluate the effectiveness of systems and processes;
- **Audit** is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria;
- **Continuous Audits** are repeated audit cycles to ensure new controls can be identified and tested as they arise.

Where deficiencies have been identified through any of the above, there must be evidence that recommendations and action plans have been developed and changes implemented.

The frequency and detail of the monitoring process is described in the table below:

Monitoring	Method	Frequency	Lead	Reporting to
All women (100%) with an abnormal GTT result are reviewed by DSM+/- DSN and dietician	Audit	Annual	Diabetes Specialist Midwife	Maternity Directorate
All women diagnosed with GDM are offered a follow-up GTT at 6-8 weeks postnatal	Audit	Annual	Clinical Lead for Diabetes in Pregnancy	Maternity Directorate

9. Associated Documents

- Guideline for Sliding Scale Insulin Following Antenatal Administration of Betamethasone to Diabetic Women
- Preconception Care and Antenatal Management of Women with Pre-existing Type 1 or Type 2 Diabetes
- Intrapartum and Postpartum Management of Women with Type 1, Type 2 or Gestational Diabetes
- Recognising and Treating Diabetic Emergencies in Pregnant Women with Diabetes
- Babies at risk of Hypoglycaemia

10. References

Crowther C, Hiller J, Moss J, McPhee A, Jeffries W and Robinson J. 2005. *Effect of treatment of gestational diabetes mellitus on pregnancy outcomes.* The New England Journal of Medicine. 352: 24: 2477-86.

Landon M, Spong C, Thom E, Carpenter M, Ramin S, Casey B, Wapner R, Varner M, Rouse D, Thorp J, Sciscione A, Catalano P, Harper M, Saade G, Lain K, Sorokin Y, Peaceman A, Tolosa J and Anderson G. 2009. *A multicentre, randomized trial of mild gestational diabetes.* The New England Journal of Medicine. 361: 14: 1339-48.

Scott D, Loveman E, McIntyre L and Waugh N. 2002. *Screening for gestational diabetes: a systematic review and economic evaluation.* Health Technology Assessment. 6: 11. Updated 2010

National Institute for Clinical Excellence (2005) Antenatal Care: Routine care for the healthy pregnant woman. www.nice.org.uk

National Collaborating Centre for Women's and Children's Health and National Institute for Health and Clinical Excellence (2008) Diabetes in Pregnancy – management of diabetes and its complications from preconception to the postnatal period. www.nice.org.uk

Appendix A – Plan for Dissemination of Procedural Documents

To be completed by the Head of Corporate Affairs and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	**Gestational Diabetes, Diagnosis and Management**		
Date finalised:	20th January 2012	**Dissemination lead: Print name and contact details**	D Wyllie Ext 2601
Previous document already being used?	**Yes**		
If yes, in what format and where?	Intranet		
Proposed action to retrieve out-of-date copies of the document:	Archive previous version on the DMS		
To be disseminated to:	**How will it be disseminated, who will do it and when?**	**Paper or Electronic**	**Comments**
All staff	Intranet	E	

Dissemination Record to be used once document is approved.

Date put on register / library of procedural documents	30th January 2012	**Date due to be reviewed**	20th January 2015	
Disseminated to: (either directly or via meetings, etc)	**Format (i.e. paper or electronic)**	**Date Disseminated 30th January 2012**	**No. of Copies Sent**	**Contact Details / Comments**
All staff	E		0	

Appendix B – Equality Impact Assessment Tool

Policy/Function Details	
Name of Policy/Function[1], Service, Plan, SLA, Function, Contract or Framework:	Gestational Diabetes, Diagnosis and Management
Is this a new policy or function?	New ☐ Existing ☐ Updated ☒
Responsible Manager	Nina Johns
Date Assessment Completed:	20th January 2012
Sources of Data	

Screening Assessment					
Equality Group	**Impact**		**Status of Impact**		**Brief Detail of impact**
	Yes	**No**	**Positive**	**Negative**	
Race, Ethnicity, Colour, Nationality or national origin (incl. Romany Travellers, refugees and asylum seekers)		X			
Gender or Marital Status of Men or Women		X			
Gender or Marital Status of Transsexual or Transgender people		X			
Religion or belief		X			
Physical or Sensory Impairment		X			
Mental Health Status		X			
Age or perceived age		X			
Sexual Orientation (Gay, Lesbian, Bisexual)		X			
Offending Past		X			
Other Grounds (i.e. poverty, homelessness, immigration status, language, social origin)		X			

[1] Policy/Function for the purpose of this document also includes Services, Plans, SLAs, Contracts, Care Pathways and Service or Care Frameworks.

Assessment Narrative
Are there any alternative service/policy provisions that may reduce or eradicate any negative impacts?
N/A
How have you consulted with stakeholders and equalities groups likely to be affected by the policy?
Maternity Directorate
What are your conclusions about the likely impact for minority equality groups of the introduction of this policy/service?
None
How will the policy/service details (including this Equality Impact Assessment) be published and publicised?
Intranet
How will the impact of the policy/service be monitored and reviewed?
As per section 8 of this policy

Assessor Name:	Nina Johns
Assessor Job Title:	Consultant Lead for Delivery Suite
Date Completed:	20th January 2012

Appendix C – Policy Checklist

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Has all the information on the front page been completed?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Is the responsible policy leads name and title clearly printed?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	Maternity Directorate
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Are the intended outcomes described?	Yes	
	Is the language used in the document clear, jargon free and spelt correctly?	Yes	
5.	**Format**		
	Does the policy conform to the prescribed policy format?	Yes	
6.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited using Harvard referencing?	Yes	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
7.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
8.	**Document Control**		
	Has a version control sheet been placed at the front of document, and been filled out correctly?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		
	Is there a plan to review or audit compliance with the document?	Yes	
10	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11	**Equality Assessment**		
	Has an equality impact assessment been carried out?	Yes	

Individual Approval			
If you are happy to approve this document, please sign and date it below, and put the document onto the DMS for final approval			
Name	Nina Johns	Date	20th January 2012
Signature			
Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name	Tracey Johnston	Date	20th January 2012
Signature			

Appendix D – Flowchart for referring women with gestational diabetes