**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)
  - ☐ Basal bolus 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: _____

**TABLE 1**: To calculate Total Daily Dose (TDD):
____kg (pre-pregnancy weight) x 0.3 = ____units/day

**Discharge Instructions:**

- ☐ Advise patient to:
  - Arrange follow-up appointment with Diabetes Specialist _____weeks after discharge
  - Arrange follow-up appointment with Diabetes Education Program 6 to 8 weeks after discharge
  - Schedule 75 OGTT 6 weeks to 6 months post-delivery for women with GDM
  - 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.