GLUCOSE TOLERANCE TEST

Northland PATHOLOGY

This form must be completed by the Phlebotomist

Surname	Given Names	Title	DOB / /
Sex	**Address**	**Phone no.**	**NHI**

Section 1 – must be completed before starting the GTT

1. **Is the patient taking metformin or insulin?** **Yes / No**
   If 'Yes', **Has the patient taken metformin or insulin in the last 7 days?** **Yes / No**
   If 'Yes', do not continue
2. **Has the patient fasted for at least 10 hours and no more than 16 hours?** **Yes / No**
   If 'No', record how long ……..
3. **Is the patient pregnant?** **Yes / No**
4. **Is the patient aware they must stay in the Collection Centre for 2 hrs during the test?** **Yes / No**
5. **Does the patient have any food allergies?** **Yes / No**
   If 'Yes', consult with HOD

Phlebotomist: _____ **Date:** _____

Section 2

Date: _____

Fasting blood sample:

Time: _____ **Collected by:** _____

Glucose drink:

Dose: _____ **Expiry date:** _____

Checked by: _____

Time: _____ **Supervised by:** _____

2 hour blood sample:

Time: _____ **Collected by:** _____

Collection details on fasting and 2 hour tubes and form checked by: _____

Comments*

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