GLUCOSE TOLERANCE TEST

Awanui Labs
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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 diabetes drugs or Insulin?** **Yes / No**
   If 'Yes', continue to question 2
   If 'No' skip to question 3
2. **Is the patient taking Metformin ONLY?** **Yes / No**
   If 'Yes' continue to question 3
   *If 'No' – **DO NOT PROCEED** – refer to NPL-PPM-023 GTT on how to proceed*
3. **Has the patient fasted for at least 10 hours and no more than 16 hours?** **Yes / No**
   If 'No', record how long ……
4. **Is the patient pregnant?** **Yes / No**
5. **Is the patient aware they must stay in the Collection Centre for 2 hrs during the test?** **Yes / No**
6. **Is the patient aware that the test will be discontinued if they vomit during the test?** **Yes / No**
7. **Has the patient had normal activity prior to the test?** **Yes / No**
8. **Has the patient been well during the last 2 weeks?** **Yes / No**
9. **Has the patient had a normal diet over the last 3 days?** **Yes / No**
10. **Does the patient have any food allergies?** **Yes / No**
    If 'Yes' refer to further information in NPL-PPM-023

Phlebotomist: _____ **Date: _____**

Section 2

Date:

Fasting blood sample

Time: _____ **Collected by: _____**

Glucose drink

Dose: _____ **Expiry date: _____**

Time: _____ **Checked by: _____**

Confirmed by: _____

2 Hour blood sample

Time: _____ **Collected by: _____**

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

Comments* ……