2-Hour Glucose Tolerance Test

Patient Information	
Patient Name:	
Date of Birth:	Gender:
Contact Information:	
Medical Record Number:	
Date of Test:	

Test Preparation

Fasting Duration: ____________ hours

Fasting Blood Glucose Level: ______________ mg/dL (_____________ mmol/L)

Patient's Health Status:

- ☐ Well
- ☐ Unwell (Please specify reason: ____________________________)

Medications Taken:

- ☐ Yes
- ☐ No (If yes, list medications: ______________________________)

Allergies:

- ☐ Yes
- ☐ No

(If yes, specify allergies: _______________________________)

Test Procedure

Time of Glucose Solution Ingestion: _____________ (hh:mm AM/PM)

Amount of Glucose Solution Consumed: ____________ ounces (__________ mL)

Administration Route:

- ☐ Oral
- ☐ Intravenous (Specify if different: ______________________________)

Blood Glucose Measurements

Baseline Fasting Blood Glucose: _________________ mg/dL (_____________ mmol/L)

2-Hour Blood Glucose: ________________ mg/dL (__________________ mmol/L)

Interpretation

- ☐ Normal: Blood glucose level within the expected range.
- ☐ Impaired Glucose Tolerance: Blood glucose level elevated but not in the diabetes range.
- ☐ Diabetes: Blood glucose level in the diabetes range.
- ☐ Other (Specify): ____

Recommendations

- ☐ No further action required.
- ☐ Additional testing needed: ______________________________
- ☐ Referral to a specialist: ______________________________
- ☐ Lifestyle and dietary recommendations: ______________________________

Comments and Observations