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