



East Bay Perinatal Medical Associates

Referral Form – Sweet Success Diabetes in Pregnancy Program

Referring physician—please fax or mail completed referral form along with all prenatal records.

Referring Physician/Provider: _____ Provider Phone: _____

Physician/Provider Address: _____

Please Check: Co managed for Sweet Success: Yes No
Transfer of Complete OB Care: Yes No

Patient Information

Patient Name: _____ Address: _____

Date of Birth: _____

Phone Number (Day): _____ Insurance Company: _____

Language: _____ Insurance Authorization No.: _____

LMP: _____ EDD: _____ Insurance ID #: _____

Gravida: _____ Para: _____ Was patient diabetic before her pregnancy? Yes No

Test Results: Please complete all information specific to your patient

1st Trimester diabetes screening (<13 wks) **1 Hour GTT results:** _____ Date: _____

HgbA1C: _____ Date: _____ **3 Hour GTT results:** _____ Date: _____

2 Hour GTT results: Date: _____ FBS _____

FBS _____ 1-Hour _____

1 Hour _____ 2-Hour _____

2 Hour _____ 3-Hour _____

When Referring a Patient

IMPORTANT: To avoid delays in scheduling, please make sure to mail or fax entire prenatal chart to the appropriate office (see below).

(Please include copies of the patient's):

- Registration form
- Insurance card/information
- Abnormal labs
- Prenatal records
- Ultrasound reports

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