UCSF Benioff Children's Physicians

Maternal-Fetal Medicine

REFERRAL FORM

Sweet Success Diabetes-in-Pregnancy Program

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 (Daytime): _____ Insurance Co: _____

Language: _____ Insurance Co Auth# : _____

LMP: _____ EDD: _____ Insurance ID #: _____ RX 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 weeks) 1 Hr GTT Results: _____ Date: _____

HgbAIC: _____ Date: _____ **3 Hr GTT Results:** _____ Date: _____

2 Hr GTT Results: _____ Date: _____ FBS: _____ **1 Hr Results:** _____ **2 Hr:**_____ **3 Hr:** _____

FBS: _____ **1 Hr Results:** _____

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 the following copies:

- ☐ **Registration**
- ☐ **Abnormal Labs**
- ☐ **Prenatal Records**
- ☐ **Ultrasound Reports**
- ☐ **Insurance card/Information and RX card**

(Please include a copy of the front and back)

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