East Bay Perinatal Medical Associates

Referral Form — Prenatal Diagnosis

Referring Physician/Provider: ______________________________

Patient Information

Patient Name: ______________________________

Date of Birth: ______________________________

L.M.P.: ______________________________

E.D.C.: ______________________________

❑ Previous East Bay Perinatal ultrasounds

❑ Previous ultrasounds with this pregnancy: If yes, where: ______________________________

Phone Number (Day): ______________________________

Phone Number (Evening): ______________________________

Insurance Company: ______________________________

Insurance Authorization No.: ______________________________

Insurance ID #: ______________________________

Patients—please bring your insurance card and this form to your appointment.

Exam Requested

❑ Ultrasound

❑ Genetic Counseling

❑ Consultation with Maternal-Fetal Medicine Specialist

❑ Genetic Amniocentesis

❑ CVS

❑ CA State Expanded A.F.P. Follow-Up

❑ 1st Trimester Blood Screen 9-13 weeks (Free Beta/Papp A)

❑ Nuchal Translucency Measurement Ultrasound (11-13 weeks, 6 days)

❑ Other: ______________________________

Indication for Referral

Indications:

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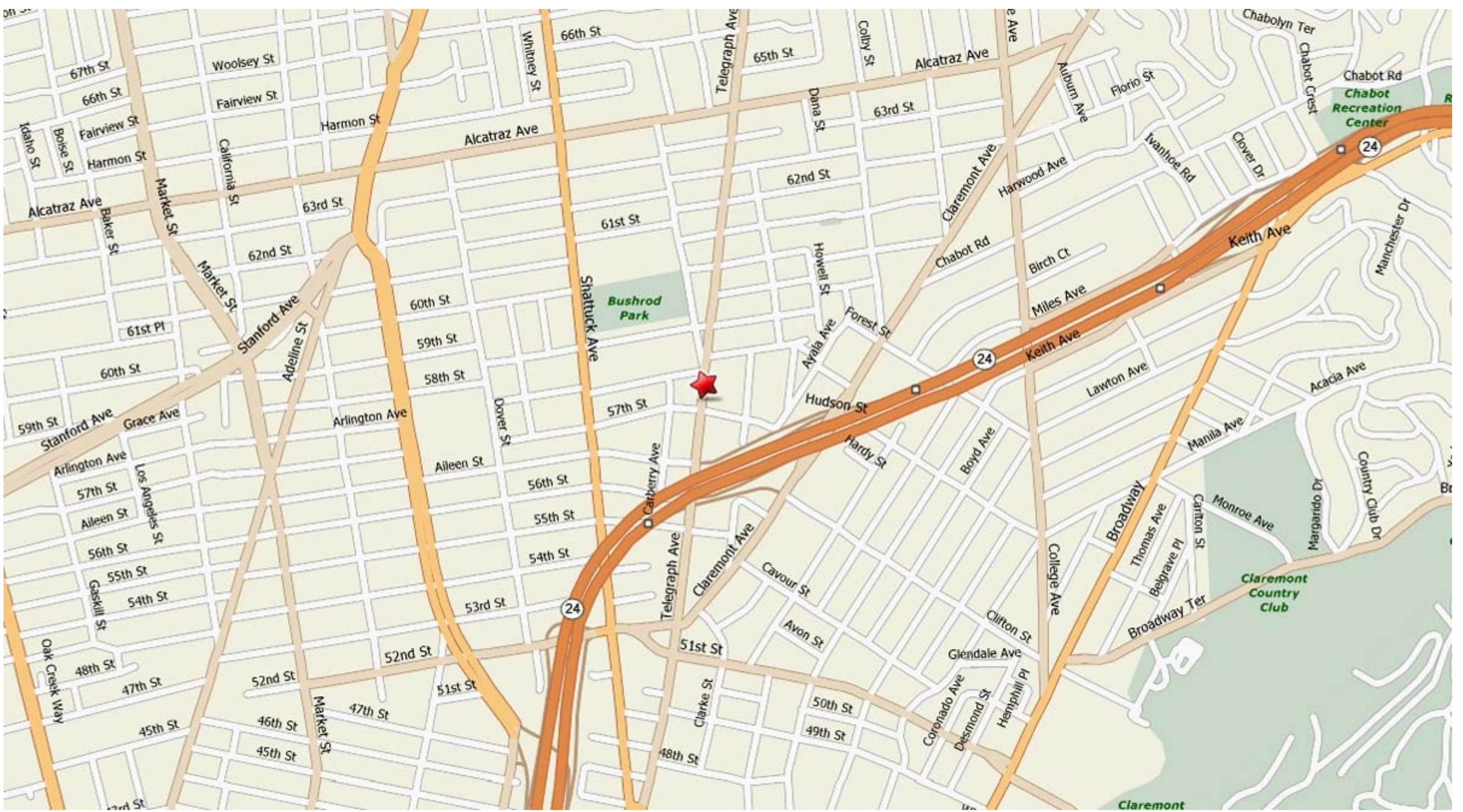
Referring physicians—please mail or fax any abnormal labs, prenatal records, ultrasound reports, etc., directly to the appropriate office:

❑ 5730 Telegraph Avenue, Suite 117, Oakland, California 94609 • Telephone (510) 204-1507 • Fax (510) 601-7092

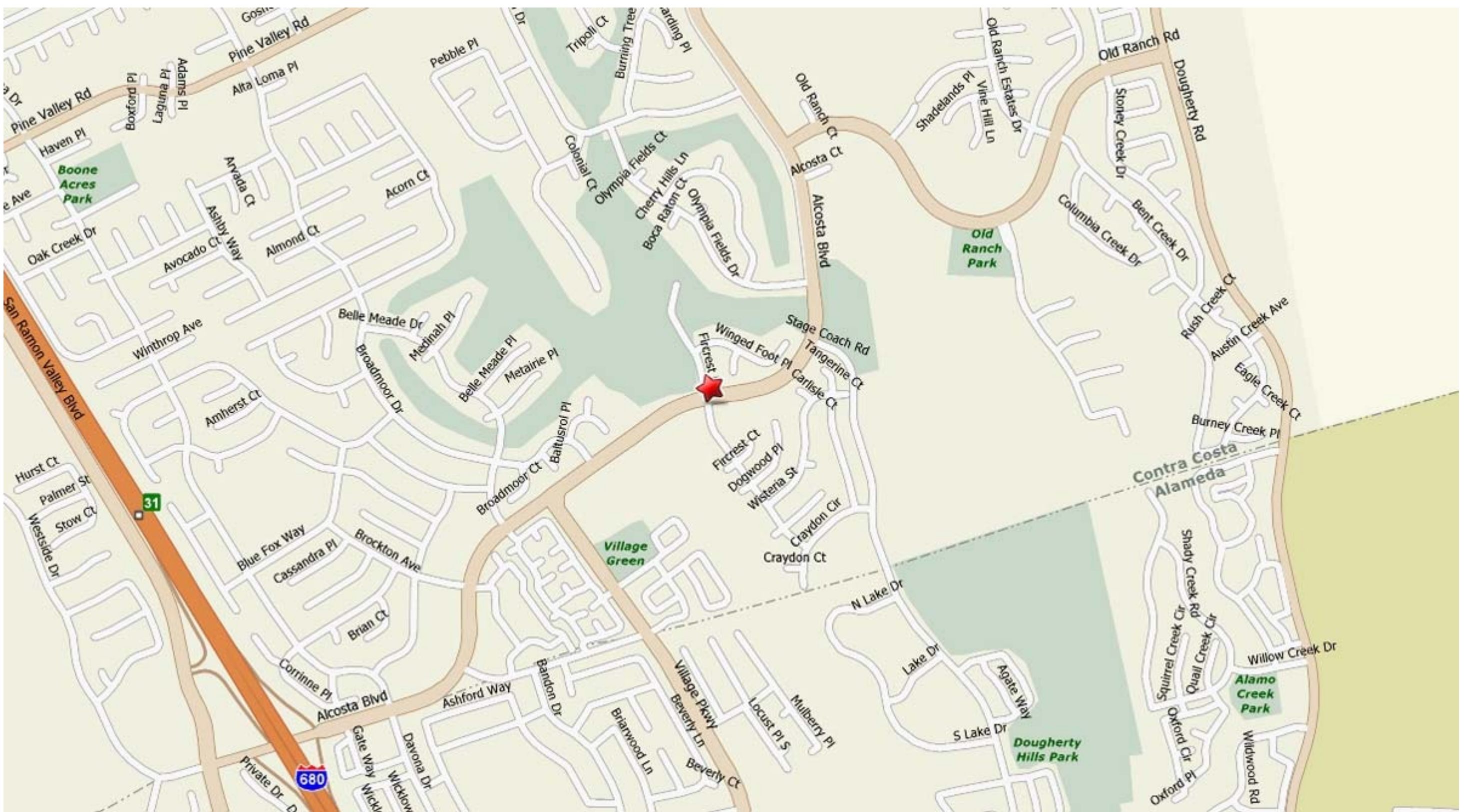
❑ 9260 Alcosta Blvd, Building C, Suite 17A, San Ramon, CA 94583 • Telephone (925) 803-2222 • Fax (925) 803-2223

❑ 2191 Mowry Avenue, Suite 500-E, Fremont, California 94538 • Telephone (510) 794-4601 • Fax (510) 794-4790

Oakland Ultrasound Office: 5730 Telegraph Ave., Suite 117, Oakland, CA 94609



San Ramon Office: 9260 Alcosta Blvd., Suite 17A, Bldg. C., San Ramon, CA 94583



Fremont Office: 2191 Mowry Avenue, Suite 500-E, Fremont, CA 94538