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:
Sweet Success Only? ☐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 #:______________________________

Was patient diabetic before her pregnancy? ☐ Yes ☐ No

I Hour GTT results: _______________________ Date: ____________________

If >180, fasting blood sugar: __________________ Date: ____________________

3 Hour GTT results: FBS __________________

1-Hour__________________

2-Hour __________________

3-Hour __________________ Date: ____________________

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).

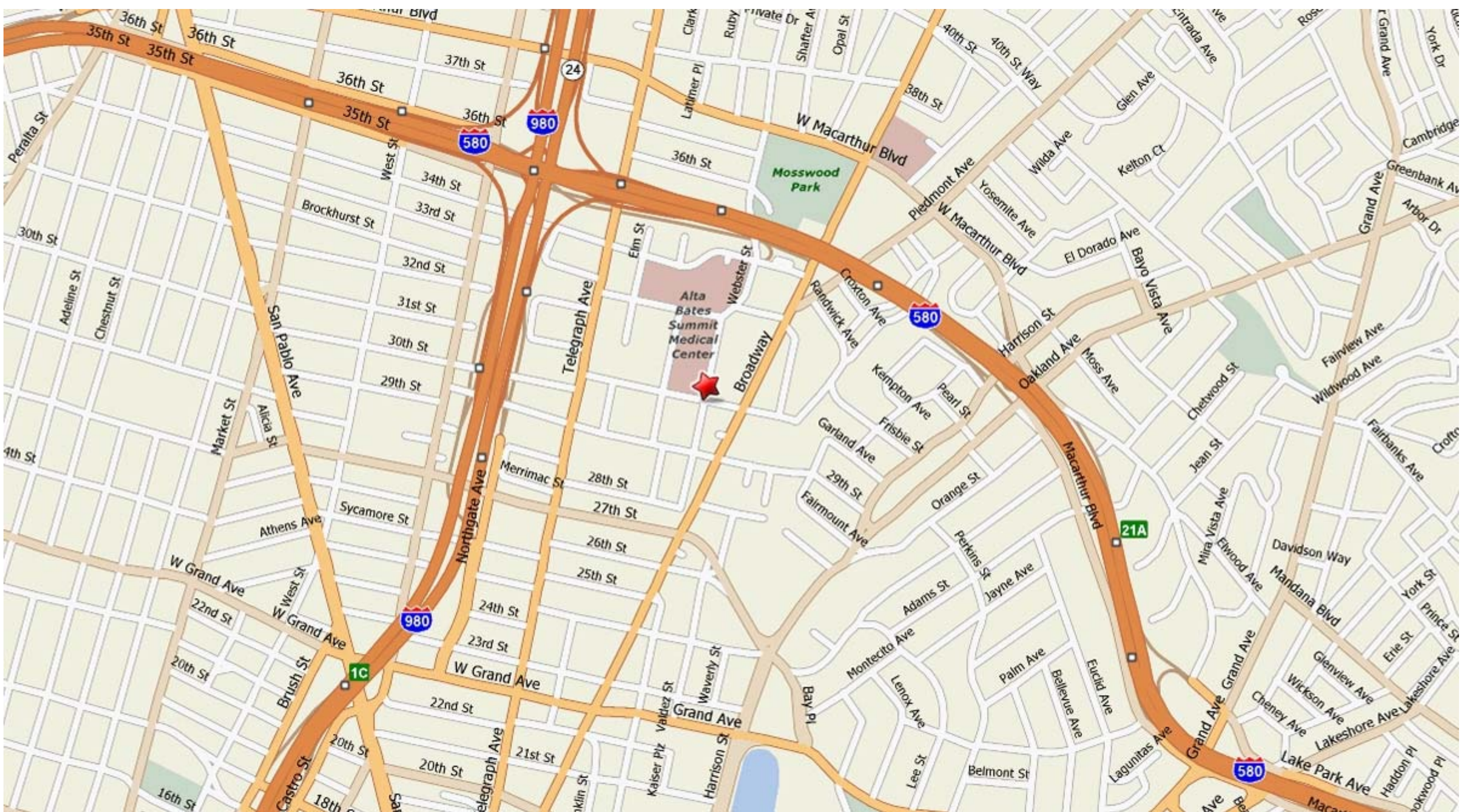
(Please include copies of the patient's:

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

❑ 350 30TH Street, Suite 208, Oakland, California 94609 • Telephone (510) 444-0790 • Fax (510) 869-6225

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

Oakland Consultation Office: 350 30th Street, Suite 208, Oakland, CA 94609



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