**ALTA BATES SUMMIT PERINATAL CENTER**

**PATIENT REFERRAL**

## ** PLEASE COMPLETE FORM AND ENCLOSE ALL MEDICAL RECORDS **

Patient Name: _____ DOB: _____

Address: _____ City: _____ Zip _____

Telephone #:_____

Social Security: _____

Language: _____

EDC: _____ G___ P___

Referring Provider: _____Telephone #:_____ Fax #: _____

Insurance Coverage: _____ID Number: _____

Reason for Referral: _____

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Please check the following:

__ Transfer of care __ Consultation(s) with Perinatologist

**PLEASE INCLUDE THE FOLLOWING:**

- Progress Note
- Recent Labs
- History and Physical
- Recent Ultrasounds /and or reports
- Copy of Insurance Card ( Front and Back )

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