Sutter East Bay Medical Group
Affiliated with the Sutter East Bay Medical Foundation

Sutter Health
Alta Bates Summit Medical Center

Sutter East Bay Medical Group OB/CNM Hospitalist Program
DATE: _____ Clinic: _____

Patient Name:_____DOB_____G/P_____
EDD_____GA_____ Patient Ph #_____ Preferred Language

Relevant Problem List:_____

_____

****Please only fax complete records when they are unavailable in EHR/Epic*

Complete Record Includes:
- □ Prenatal Record
- □ Original Lab Reports
- □ Original Ultrasound Reports
- □ Prior Operative Reports
- □ Tubal Consent
- □ Medical Card/Face Sheet
- □ Pediatrician Selected
- □ GBS

Sutter East Bay Medical Group OB/CNM Hospitalist Program RightFax: (510) 506-7762

□ **L&D TRIAGE to Alta Bates Hospital Labor & Delivery** for: □ Labor check □ SROM □ PTL □ Bleeding □ Decreased FM □ r/o Preeclampsia □ other _____
- □ Call Labor and Delivery Triage with verbal report (510) 204-1780
- □ Labor & Delivery fax (510) 848-2160

□ **INDUCTION** to Sutter East Bay Medical Group OB/CNM Hospitalist Program RightFax. Yesenia Ramirez (L&D Secretary) will contact the patient and fax confirmation to clinic.
- □ Postdates □ SROM □ Oligo □ IUGR □ Cholestasis □ IUFD □ A1DM □ A2DM □ CHTN
- □ Gestational HTN □ Preeclampsia □prior IUFD □ other_____

Previous C/S: □ No; □ Yes, number of previous C/S____: Uterine Surgery: □ Yes □ No

Alta Bates Summit Medical Center-Alta Bates Hospital -- Ph: (510) 204-1352 / Fax: (510) 204-4026

□ **Antepartum Testing**
- □ Use Alta Bates Hospital AP Testing order form, fax & schedule with AP Testing directly

Alta Bates Summit Perinatal Center -- Ph: 510-869-8425 / Fax: (510) 506-7710

□ **TOLAC CONSULT**
- □ Include prior operative report & complete prenatal records

□ **VERSION CONSULT**

□ **PLANNED C/S CONSULT**
- □ Fax completed Patient Referral form
- □ Number of previous C/S: ____ Uterine Surgery: □ Yes □ No

□ **TRANSFER OF CARE AND CONSULT**
- □ Fax complete Patient Referral form for Alta Bates Summit Perinatal Center
- □ Fax complete prenatal records

□ **"SWEET SUCCESS", California Diabetes and Pregnancy Program**
- □ Fax completed Patient Referral form
- □ Fax complete prenatal records

REFFERING CLINIC PROVIDER:_____**CLINIC CONTACT**_____**CLINIC PHONE**_____**CLINIC FAX**_____