Alta Bates Summit Perinatal Center
Referral Form – Sweet Success Diabetes in Pregnancy Program

Referring physician – please fax completed referral form along with all prenatal records.

Referring Physician/Provider: ________________________ Provider Phone: ________________

Physician/Provider Address: ________________________ Provider Fax: ___________________

Please Check:

- RD Care and MFM Consultation(s): (formerly called co-managed) ☐ Yes ☐ No
- Transfer of Complete OB Care: ☐ Yes ☐ No
- Referring Provider a CPSP Participant ☐ Yes ☐ No

Patient Name: ________________________ Address: _________________________________

Date of Birth: __________________________ ____

Phone Number: ________________________ Insurance Company: _______________________

Preferred Language: _____________________ Insurance ID No.: _________________________

LMP: _____________ EDD: _____________ Diabetic Before Pregnancy?: ☐ Yes ☐ No

---

Test Results: Please complete all information specific to your patient

1st Trimester Diabetes Screening (< 13 wks)

HgbA1C: _________ Date: ________

2 Hour GTT Results: _________ Date: ________

FBS: _______________

1 Hour: ______________

2 Hour: ______________

1 Hour GTT Results: ________ Date: _________

3 Hour GTT Results: ________ Date: _________

FBS: ______________

1 Hour: ____________

2 Hour: ____________

3 Hour: ____________

IMPORTANT: To avoid delays in scheduling, please make sure to include the entire prenatal chart when faxing the referral, including the following:

- ☐ Registration Form
- ☐ Insurance Card/Number
- ☐ Laboratory Tests
- ☐ Prenatal Records
- ☐ Ultrasound Reports

350 30th Street, Suite 205, Oakland, CA 94609 Telephone: (510) 869-8425 Fax: (510) 506-7710