UCSF Medical Center
Women's Health

OB REFERRAL INTAKE FORM

Phone: 415-353-2895 **Fax: 415-502-4616**

Name:		Phone:
DOB:	Insurance:	ID#
Group#	Emergency contact:	
Phone:	Relationship:	
Interpreter Needed? □ Y □N	Language:	

Referring to: □ MFM Preconception □ MFM Pregnant
Visit Type: □ Transfer of Care □ Co-Manage □ Consult only
For Patients with Diabetes, who will manage Blood Sugar? □ UCSF □ Local program
Planned Location for Delivery? □ UCSF □ TBD pending recommendation □ Local hospital
Has Prior Authorization been obtained? □ Y □ N Will insurance cover labs drawn at UCSF? □ Y □ N

Referring Clinician:		E-mail:
Cell#	Group Name & Specialty:	
Office Contact (Name)	Office#	Fax#
Provider Preferred Contact for urgent issues: □ Cell □ E-Mail □ Office Contact		

Diagnosis:		
What is the specific referral question?		
EDD:	Dating by LMP□ US □ IVF □	G: P:
Does the patient need an ultrasound the day of the consult? □ Y □ N Current medications:		

Please send us the following and select "Plan to do at UCSF" if you would like us to arrange studies during patients visit.
*****Please send us any records of prior births, US reports, echo results and prenatal labs*****

Test	Already Completed	Results sent to UCSF	Plan to do at UCSF
Prenatal Labs*	□ Y □ N □ NA	□ Y □ N	□ Y
NT ultrasound*	□ Y □ N □ NA	□ Y □ N	□ Y
First Tri Screening*	□ Y □ N □ NA	□ Y □ N	□ Y
Fetal Anatomic Survey* (level I or II)	□ Y □ N □ NA	□ Y □ N	□ Y
Fetal Echo	□ Y □ N □ NA	□ Y □ N	□ Y
Maternal Echo	□ Y □ N □ NA	□ Y □ N	□ Y
Prenatal Labs	□ Y □ N □ NA	□ Y □ N	□ Y
Other Labs (eg rheumatology labs):			
Other imaging (CT, MRI):			

***Required**

PLEASE PREPARE YOUR PATIENT TO STAY AT UCSF FOR THE ENTIRE DAY IF NECESSARY!

*****IF YOUR REFERRAL IS EMERGENT, PLEASE CONTACT OUR PEDIATRIC ACCESS CENTER AT (415)-353-1611*****