UCSF Benioff Children's Hospital
Oakland

FETAL MEDICINE PROGRAM REFERRAL FORM

747 52nd St., Oakland, CA 94609 • Phone: 510-428-3156 • Fax 510-428-3542

Fax your referrals to 510-428-3542.

DATE_____

PATIENT INFORMATION

Patient's First Name_____

Last Name _____

DOB _____/_____/_____ Gender ☐ Female ☐ Male

Parent/Guardian Name_____ ☐ N/A

DOB _____/_____/_____ Relationship_____

Street Address _____

City_____State_____Zip _____

Daytime Phone (_____) _____

Alternate Phone (_____)_____

Interpreter needed? ☐ No ☐ Yes

If yes, what language? _____

MEDICAL INFORMATION

Diagnosis/Reason for referral_____

_____

_____

Is this an urgent referral? ☐ No ☐ Yes

Reason for urgent referral_____

_____

_____

PATIENT HISTORY

Brief History/Work Up _____

_____

_____

Previous visits to UCSF Benioff Children's Hospital Oakland for this problem?
☐ No ☐ Yes

_____

_____

_____

INSURANCE INFORMATION

Subscriber Name _____

DOB _____/_____/_____

Health Plan _____

Authorization # _____

Group # _____

Member ID_____

Secondary Insurance, if any_____

REFERRING MD CONTACT INFORMATION

Referring MD_____

Best way to reach me is by ☐ Phone ☐ Fax ☐ Pager

Phone (_____) _____

Fax (_____)_____

Office Name _____

Office Street Address _____

City_____State_____Zip _____

Pager (_____)_____

ATTACHMENTS

Please note: Sending this information helps us give your patient the most effective care.

☐ Prenatal Records and history

☐ Pertinent Diagnostic/Imaging Studies

☐ Prenatal Lab Studies, Prior consultations, other pertinent medical records.

If lab or imaging studies have been completed at Children's, we will retrieve the results. You do not have to send them.

Please call 510-428-3156 if you would like to speak with the consulting physician prior to the appointment.