

# Diabetes in Pregnancy REFERRAL FORM

<b>Office Use</b> Date: _____
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**Diabetes in Pregnancy Program**  
University of Washington Medical Center  
Department of Obstetrics and Gynecology  
Box 356460  
Seattle, WA 98195-6460

**Phone: (206) 598-4070**  
**Fax: (206) 685-4694**

Today's Date \_\_\_\_\_

## PATIENT INFORMATION

Patient Name \_\_\_\_\_ LMP \_\_\_\_\_ EDC \_\_\_\_\_  
SS# \_\_\_\_\_ DOB \_\_\_\_\_ Parity \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Partner's Name \_\_\_\_\_  Married  Single  
Insurance \_\_\_\_\_ UWMR# \_\_\_\_\_  
Group Health # (if applicable) \_\_\_\_\_ PIC# \_\_\_\_\_  
Reason for Referral:  Consult only  
 OB care with delivery at UWMC

## REFERRING MD INFORMATION

Obstetrician's Name \_\_\_\_\_ UPIN# \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Backline Phone \_\_\_\_\_ FAX \_\_\_\_\_  
Endocrinologist's Name \_\_\_\_\_ UPIN# \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Backline Phone \_\_\_\_\_ FAX \_\_\_\_\_  
Primary Care Provider's Name \_\_\_\_\_ UPIN# \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Backline Phone \_\_\_\_\_ FAX \_\_\_\_\_

## PATIENT REFERRAL CHECKLIST

Be sure to fax the following, along with this completed form, to **(206) 598-4694 (Attention: Becky Harney)**:

- Pertinent prenatal records
- All OB and diabetes lab work
- All ultrasound reports from current pregnancy
- Serum screening report
- Insurance preauthorization, if applicable