


**Project Guardian Maternity- Remote Patient Monitoring Referral Form- Attachment 1A
EXTERNAL REFERRAL**

Referral Date*	Adnab Referral Fax Number	Adnab Referral Email	 Remote Patient Monitoring Referral Form: Maternity
	888-521-2969	ssanchez@adnabresearch.com	
Patient Demographics			
First Name, Last Name*	Date of Birth*	Address*	Phone Number*
Alternate Contact Number	EDC*	Preferred Member Language	
		<input type="checkbox"/> Language assistance needed	
Member Email Address			
Referring Provider Information			
OB Provider/Practice Name*	OB Provider Contact Phone #*	Provider Fax #	Preferred Method of Contact
			<input type="checkbox"/> FAX <input type="checkbox"/> PHONE
Eligibility Screening (select all that apply)			
Condition/Diagnosis		Baseline (if available)	
<input type="checkbox"/> Gestational Hypertension (current or history of)		Most recent BP (include date):	
<input type="checkbox"/> Pre-eclampsia (current or history of)		Most recent BP (include date):	
<input type="checkbox"/> Eclampsia (history of)		Most recent BP (include date):	
<input type="checkbox"/> Gestational Diabetes (current or history of Type I or Type II)		Most recent BS (include A1C if known):	
<input type="checkbox"/> Multiple Pregnancy			
<input type="checkbox"/> Advanced Maternal Age (AMA): Age 35 years or >		Patient Age:	
<input type="checkbox"/> Class II/III Obesity (BMI 35 or >)		BMI:	
Brief summary of referral reason or pertinent information (include medication list, lab reports, previous vital signs)			



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*** Indicate required fields to be completed**

1. Complete referral Form
2. Submit referral form via fax (**888-521-2969**) or email Silvia Sanchez (**ssanchez@adnabresearch.com**)
3. Optional: Warm transfer line: **702-605-6467 (Available M-F 8:5 PST)**