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Maternal Fetal Medicine Consult & Ultrasound Referral Form

*ONCE THE PATIENT IS SCHEDULED, PLEASE HELP US COMPLETE THIS REFERRAL FORM AND INCLUDE THE FOLLOWING INFORMATION:

(1) DEMOGRAPHIC INFORMATION
(2) LEGIBLE COPY OF INSURANCE CARD FRONT/BACK
(3) PERTINENT MEDICAL RECORDS (blood type and AB screen)

Patient Name: (Last, First, MI)____
Date of Birth: _________________________ Age:______ Medical Record Number: ________________________
Spouse's Name: ____ Spouse's Birthdate: __________________
Patient Phone#: _______________________ Preferred Language:__________________ Interpreter Needed: Y/N
Number of Fetuses____ LMP/EDD________ Requested timeframe for appointment: ______ (days) _____ (weeks)
Requesting Provider:_____________________________ Phone #__________________ Fax# _______________

INDICATION(S) /DIAGNOSIS CODE(S)____
☐ v28.3 Screening for Malformations via US (for use with routine anatomy US)

PERMISSION TO ORDER FURTHER TESTS AS RECOMMENDED BY MFM: Yes or No

Ultrasound Request
- ☐ **Initial ultrasound**
- ☐ **Repeat ultrasound**
- ☐ Anatomy
- ☐ Cervical Length
- ☐ Fetal growth assessment
- ☐ Fetal Echocardiogram
  Indication ________________________

☐ Multiple Gestation: (**check one**)
☐ Twin ☐ Triplet ☐ Higher order

☐ Placenta: (**check one**)
☐ Previa ☐ Abruption

☐ Viability

☐ Suspected fetal anomaly
Describe ____________________________

Ultrasound with genetic counseling
- ☐ AMA (>35 years/ >32 years with twins)
- ☐ Abnormal serum screening (send results)
- ☐ Genetic amniocentesis**: (> 15weeks)
- ☐ Family History__________________________
- ☐ Fetal anomaly__________________________
- ☐ First trimester screen* (11-13 weeks)
- ☐ NIPS/cfDNA (> 10 weeks)**
- ☐ Review Genetic testing options**:
  Requested at _____weeks gestation

☐ Genetic Counseling only
Indication ___________________________

☐ Patient/provider declines genetic counseling
(GC required for coordination of testing)**

Antenatal Testing
- ☐ Amniotic fluid index
- ☐ Biophysical Profile: (BPP)
  Indication ________________________
- ☐ Doppler
  Indication___________________________
- ☐ Non Stress Test: (NST)
  Indication___________________________

Maternal Fetal Medicine Consult
- ☐ MFM consult only
  Indication ____________________________
- ☐ Request of co-management of patient by MFM
  Indication______________________________
- ☐ Preconception Consult
  Indication______________________________
- ☐ MFM consult with ultrasound
  Indication____________________________

Referring Physician signature: ____