Women's Specialty Care, LLC
Optimizing Pregnancy Outcomes

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Maternal Fetal Medicine Consult & Ultrasound Referral Form

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH THIS REFERRAL:

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:_____

Spouse's Name:_____ Spouse's Birth date: _____

Patient Phone#: _____ Preferred Language:_____ Interpreter Needed: Y/N

Number of Fetuses____ LMP/EDD_____ Requested time frame for appointment: _____ (days) _____ (weeks)

Requesting Provider:_____ Phone #_____ Fax# _____

INDICATION(S)/DIAGNOSIS CODE(S)_____

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

PERMISSION TO PERFORM MFM CONSULT FOR ABNORMAL ULTRASOUND FINDINGS: Yes or No

Ultrasound Request

□ Dating ultrasound
□ First trimester screen (11-13 weeks)
□ Repeat ultrasound
□ Anatomy
□ Genetic amniocentesis*: (≥16 weeks, require blood type)
□ 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 _____

Antenatal Testing

□ **Biophysical Profile (BPP):**
Indication _____
Frequency _____

□ **Doppler**
Indication_____
Frequency _____

□ **Non Stress Test (NST) with AFI:**
Indication_____
Frequency _____

*Genetic Counseling:

If there is a preference please circle:
in person or **telehealth**

□ AMA (>35 years/ >32 years with twins)
□ Abnormal serum screening (send results)
□ Family History_____
□ Fetal anomaly (suspected or history of):
_____

□ Review routine Genetic testing options:
Requested at _____weeks gestation

□ Other Genetic Counseling
Indication _____

□ Patient/provider declines genetic counseling

□ Patient has had genetic testing with this pregnancy (please send results)

Maternal Fetal Medicine Consult

MEDICAL RECORDS ARE REQUIRED TO BE SENT FOR ALL CONSULT PATIENTS PRIOR TO SCHEDULING THEIR APPOINTMENTS

□ MFM consult only
Indication _____
□ Request of co-management of patient by MFM
Indication_____
□ Preconception Consult
Indication_____

□ Windward DIPP (Diabetes Program)
(**Please send GDM screening results and HbA1c if done)**

Referring Physician signature: _____ **Date:** _____