



Women's Specialty Care, LLC

Optimizing Pregnancy Outcomes

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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) _____

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 _____

Antenatal Testing

- Amniotic fluid index
- Biophysical Profile: (BPP)

Indication _____

- Doppler
Indication _____

- Non Stress Test: (NST)
Indication _____

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)

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 _____
- MFM consult with ultrasound
Indication _____
- Windward DIPP (Diabetes Program)
(Please send glucose results or A1C results with referral)

Referring Physician signature: _____