



**Elizabeth J. Ferrell Fetal Health Center  
Prenatal Integrated Clinic  
Referral Form**

7152-012 MR 06/11

**Elizabeth J. Ferrell Fetal Health Center  
Children's Mercy Hospital  
2401 Gillham Road  
Kansas City, Missouri 64108**

**Phone (toll free): (866) 281-8480  
Fax: (816) 234-9336**

**REFERRING PROVIDER:**

- We are located on the 3rd floor of the West Tower at Children's Mercy Hospital in downtown Kansas City, Missouri.
- Please **fax referral form and patient records to (816) 234-9336** at the time of making an appointment.
- Call the Fetal Health Administrative Coordinator at (866) 281-8480 if you have questions.

**Patient Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street Address City State Zip Code

**Phone Number:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Gravida:** \_\_\_\_\_ **Para:** \_\_\_\_\_

**Last Menstrual Period:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Estimated Date of Confinement (EDC):** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Maternal Diagnosis:** \_\_\_\_\_

**Fetal Diagnosis:** \_\_\_\_\_

**REQUEST FOR PRENATAL CONSULTATION:**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Cardiology             | <input type="checkbox"/> General Pediatric Surgery   | <input type="checkbox"/> Neonatology         | <input type="checkbox"/> Plastic Surgery |
| <input type="checkbox"/> Cardiovascular Surgery | <input type="checkbox"/> Genetics Counseling         | <input type="checkbox"/> Nephrology          | <input type="checkbox"/> Urology         |
| <input type="checkbox"/> Fetal Echocardiogram   | <input type="checkbox"/> Intensive Care Nursery Tour | <input type="checkbox"/> Neurosurgery        | <input type="checkbox"/> Other: _____    |
| <input type="checkbox"/> Fetal MRI              | <input type="checkbox"/> Maternal Fetal Medicine     | <input type="checkbox"/> Orthopaedic Surgery | _____                                    |

**Ordering Physician:** \_\_\_\_\_

**Contact Person for Medical Records and Appointment Times:**

**Name:** \_\_\_\_\_ **Phone Number:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Obstetric Provider:** \_\_\_\_\_

**Maternal Fetal Medicine Provider:** \_\_\_\_\_

**Delivery Hospital:** \_\_\_\_\_

**COMPLETED EVALUATIONS: Check all that apply and fax copies of completed reports.**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Fetal Echocardiogram | <input type="checkbox"/> Genetics Counseling | <input type="checkbox"/> Amniocentesis:                    | <input type="checkbox"/> Fetal Karayotype |
| <input type="checkbox"/> Fetal MRI            | <input type="checkbox"/> Level I Ultrasound  | <input type="checkbox"/> Other AF Studies (specify): _____ |   |

**COMMENTS:** \_\_\_\_\_