

# Referral Form

## CHILDREN'S MERCY FETAL HEALTH CENTER

Patient Name \_\_\_\_\_

Phone Number \_\_\_\_\_ LMP \_\_\_\_\_ EDC \_\_\_\_\_

Social Security # \_\_\_\_\_ Blood Type \_\_\_\_\_

Insurance \_\_\_\_\_ G \_\_\_\_\_ P \_\_\_\_\_

Pre-Auth# \_\_\_\_\_ DOB \_\_\_\_\_

Diagnosis \_\_\_\_\_

### Please check all tests requested:

- Biophysical Profile
- Diabetic Consult (The newly diagnosed patient must see a dietician 1 week prior to Fetal Health Center Appointment.)
- Fetal Echocardiogram (Patient seen 20-24 weeks)
- Fetal Lung Maturity Amniocentesis
- First Trimester Screen
- Genetic Amniocentesis (Patient seen after 15 weeks)
- Genetic Consult (For AMA, family hx, abnormal chromosomes, etc.)
- Level II Ultrasound/Fetal survey
- Limited Ultrasound
- New OB (This is a doctor to doctor referral. We ask that your doctor or nurse call and speak to our doctor or NP.)
- Perinatal Consult
- Other Test \_\_\_\_\_

Physician ordering \_\_\_\_\_

Contact person for appointment time \_\_\_\_\_ Phone \_\_\_\_\_

Contact person for medical records \_\_\_\_\_ Phone \_\_\_\_\_

*Please fax records and copy of insurance card at the time of making an appointment. For AMA, we need latest sonogram, prenatal flow sheet and AFP results (if they have been drawn).*

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