Children's Mercy

Elizabeth J. Ferrell Fetal Health Center
2401 Gillham Road, Kansas City, MO 64108
Phone: (816) 855-1800 Fax: (816) 302-9605

FETAL HEALTH CENTER REFERRAL FORM

PATIENT NAME: _____ PHONE #: _____

HOME ADDRESS: _____

EMAIL: _____ DATE OF BIRTH _____/_____/_____

GRAVIDA/PARA _____/_____ DUE DATE _____/_____/_____ LAST MENSTRUAL PERIOD _____/_____/_____

MATERNAL DIAGNOSIS: _____

FETAL DIAGNOSIS: _____

_____

SERVICES REQUESTED

☐ **FETAL HEALTH CENTER REFERRAL**

LEVEL II ULTRASOUND, MFM CONSULT, GENETICS CONSULT, INTEGRATED CONSULT (SEE BELOW FOR DETAILS), DELIVERY SERVICES IF NEEDED

☐ **DELIVERY SERVICES AT CMH**
- ☐ COMPLETE TRANSFER OF CARE
- ☐ COMANAGE CARE

☐ **FETAL INTERVENTION CONSULTATION**

☐ **INTEGRATED CONSULTATION ONLY**
INCLUDES SUBSPECIALISTS, NEONATOLOGY, SOCIAL WORK AND GENETICS

☐ **UNSURE- PLEASE PROVIDE AS MUCH DETAIL AS POSSIBLE:**

☐ **FETAL ECHOCARDIOGRAM**
INCLUDES CARDIOLOGY CONSULT
PH: 816-234-3209
LOCATION:
- ☐ KANSAS CITY, MO
- ☐ JOPLIN, MO
- ☐ WICHITA, KS

☐ **ONE-TIME SERVICES**
- ☐ FETAL MRI
- ☐ GENETICS CONSULT
- ☐ AMNIOCENTESIS
- ☐ CVS
- ☐ SPECIALTY CONSULT, PLEASE SPECIFY:

_____

OTHER: _____

REFERRING PROVIDER INFORMATION

OBSTETRIC PROVIDER: _____ FORM COMPLETED BY: _____

MFM PROVIDER: _____ PH# _____ FAX# _____

DELIVERY HOSPITAL (IF KNOWN): _____ **IS AN INTERPRETER REQUIRED? _____**

WHAT WE NEED FROM YOU- PLEASE FAX TO: 816-302-9605

- ☐ **THIS COMPLETED REFERRAL FORM**
- ☐ **COPY OF PATIENT INSURANCE CARD OR FULL PLAN DETAILS INCLUDING SUBSCRIBER DOB**
- ☐ **C-SECTION OP REPORTS**
- ☐ **ACOG AND CURRENT LABS**
- ☐ **ALL ULTRASOUNDS, MRI AND ECHO RESULTS**
- ☐ **GENETIC TESTING RESULTS AND CONSULT NOTES IF APPLICABLE**