PATIENT REFERRAL FOR SERVICES FORM

Indication for Referral (Diagnosis)
(Please fax copies of prenatal records; subspecialty notes; laboratory copies of maternal blood type and serum screening; all prior ultrasound results to 515-643-6899.)

Obstetric Ultrasound
LMP: ____________ EDC: ____________ EDC based on LMP/Ultrasound ____________
Number of Fetuses ____________
☐ Viability/Dating < 14 weeks
☐ First Trimester Screening/Nuchal Translucency (11-13.6 weeks)
☐ Standard (gestational age assignment/anatomic survey) (18-20 weeks)
☐ Level II specialized ultrasound & MFM consult (see below)- including but not limited to: known or suspected abnormality or increased risk; AMA; Obesity; HTN; pregestational diabetes; drug exposure; twins
☐ Growth/Repeat ultrasound - reevaluation of fetal size and/or reevaluation of specific organ(s) known or suspected to be abnormal
☐ Cervical length
☐ Limited - amniotic fluid volume; placental location

Diagnostic Testing
Patient blood type ____________
☐ Amniocentesis

Genetic Counseling
☐ Preconception (family history, prior child with abnormality, maternal age, etc)
☐ Current pregnancy (review risk-appropriate screening options, discuss abnormal result, family history, etc)
☐ Other _________________________________________________________________________________

Maternal Fetal Medicine
☐ MFM pre-pregnancy consultation
☐ MFM obstetric consultation (one time visit with no expectation for follow up)
☐ MFM obstetric co-management (follow up at PCI as determined by MFM)
☐ Transfer of care to MFM (complete management/delivery by PCI)

Physician Signature: ____________________________ Date: ____________________________