Women's Institute Referral Form

Maternal –Fetal Medicine
Reproductive Endocrinology

Patient Name:_____**DOB:**_____/_____/_____

Home phone:_____ **Alternate phone:**_____ **c or w**

Address: _____ **City:** _____**Zip:**_____

Insurance Company: _____ **Precertification? Y or N Authorization #:**_____

Referring Practice: _____ **Referring MD**_____ **Office Contact:** _____

Referring Phone: _____ **Referring Fax:** _____

Is the patient pregnant? Y or N LMP: _____ **EDD:** _____

Blood type & Antibody screen: _____ **(*Documentation required on All OB pts*)**

Is an interpreter needed? Y or N If yes, what language? _____

Preferred Location: _____ **Morehead Medical Plaza** _____ **NorthEast** _____**Ballantyne**

REFERRING PHYSICIAN PRACTICE: Patient records must be forwarded and received by the Women's Institute 1 week prior to scheduled appointment. Please send at minimum (as applicable):

- **Records from last office visit**
- **Lab and Pathology results**
- **Imaging/test results**
- **Operative notes**

OBSTETRIC INDICATIONS

ULTRASOUND* AND GENETIC COUNSELING: (possible prenatal diagnosis)

□ **Multiple Gestation (#_____)**
□ **AMA: ○ 1st Tri Screen (11-13.9wks) ○ CVS (10-12.9wks) ○ 2nd Trimester U/S (17-19 wks w/ Amnio upon request)**
□ **Abnormal 1st or 2nd Trimester Screening: ○ Spina Bifida ○ Down syndrome ○ Trisomy 18/13**
□ **Medication (or other Teratogen) exposure:** _____
□ **Family History or Maternal Disease:**_____
□ **Other:** _____

ULTRASOUND* ONLY:

□ **Anatomical survey: ○ Suspected anomaly ○ Growth/fluid discrepancy ○ Borderline AFP**
○ Dating ○ Multiple gestation (#____)
□ **First trimester screening for non-AMA patient (10.9-13.9wks)**
□ **Other (please specify):** _____

All OB ultrasounds are read by the MFM and discussed with the patient in brief consult format as necessary.

GENETIC COUNSELING ONLY: (No u/s or prenatal diagnosis)
□ **AMA**
□ **Maternal disease:** _____
□ **Medication (or other Teratogen) exposure:** _____
□ **Multiple miscarriages:** _____
□ **Family history:** _____

MFM CONSULT ONLY: ***(MFM consult does not include u/s. It is an office visit for approx. one hour of face to face consultation for discussion of medical problems, preconceptional counseling, etc)***
Reason:_____

REPRODUCTIVE ENDOCRINOLOGY

□ **Consultation (infertility, menopause)**_____

office use only:
SSN:_____Hx : _____Mailed Packet:_____ Appt date/time: _____ Physician: _____