



PATIENT REFERRAL AND CONSULTATION FORM

Fax to: (972) 566-5680

Please provide demographics, prenatal records and all labs for patient.

Patient Name _____ DOB ____ / ____ / ____ Age _____
 EDC ____ / ____ / ____ G ____ / P _____ Primary Language: _____
 Phone Number _____ Alternate Number _____
 Insurance _____ Subscriber ID _____ Group # _____
 Policy Holder Name _____ DOB ____ / ____ / ____ Relationship: _____
 Referring MD _____ Office Contact _____ Phone # _____

URGENT REQUEST: Please call our office once a referral is sent at 972-566-5600

- Vaginal bleeding Cervical shortening/insufficiency IUGR Decreased fetal movement
- Absent heart tones/bradycardia/tachycardia Low AFI Twin-to-Twin Transfusion Syndrome (TTTS)
- Hydrops Bladder Outlet Obstruction. Other _____

MATERNAL FETAL MEDICINE CONSULT: Singleton Multiples

Genetics Counseling Indication	Fetal Indication	Maternal Indication
<input type="checkbox"/> AMA (≥ 35yo at delivery) <input type="checkbox"/> Abnormal carrier screening <input type="checkbox"/> Abnormal serum screening <input type="checkbox"/> Drug/medications exposure <input type="checkbox"/> Family History of: _____ <input type="checkbox"/> Pre-conception <input type="checkbox"/> Other: _____ *Ultrasound required for all GC consults except Pre-conception	<input type="checkbox"/> Dating/Viability <input type="checkbox"/> First Trimester screening <input type="checkbox"/> Anatomic survey/Level II <input type="checkbox"/> IUGR <input type="checkbox"/> Size > Date <input type="checkbox"/> Abnormal ultrasound finding <input type="checkbox"/> Fetal Arrhythmia <input type="checkbox"/> Oligo/Polyhydramnios <input type="checkbox"/> Cervical length <input type="checkbox"/> History of pre-term birth <input type="checkbox"/> Placental Abnormality <input type="checkbox"/> Other: _____	<input type="checkbox"/> Chronic hypertension <input type="checkbox"/> Gestational hypertension <input type="checkbox"/> Diabetes: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> GDM <input type="checkbox"/> Diabetic Education <input type="checkbox"/> Fibroids <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Limited/No prenatal care <input type="checkbox"/> Other: _____ *Ultrasound required for all Diabetic Education consults

FETAL SURGERY CONSULT: Urgent (same day or next day) Routine (5 business days)

<input type="checkbox"/> Twin-to-twin transfusion syndrome <input type="checkbox"/> Bladder Outlet Obstruction <input type="checkbox"/> Hydrops <input type="checkbox"/> Spina Bifida	<input type="checkbox"/> Congenital Diaphragmatic Hernia <input type="checkbox"/> Lung Mass (CPAM) <input type="checkbox"/> Other: _____
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FETAL ECHOCARDIOGRAM Singleton Multiples

Indication: _____

FETAL CARE CENTER
 7777 FOREST LANE, STE C-742, DALLAS, TX 75230: P) (972) 566-5600; F) (972) 566-5680