PATIENT REFERRAL AND CONSULTATION FORM

Please provide demographics, prenatal and lab records for patient. Fax to: (972) 566-5680

Patient Name____________________________________**DOB** ______________ Age ______________

EDC _________________G _____ / P _______ Primary Language: _________________________

Phone Number _________________ **Insurance** ___________________ **Subscriber ID:** ____________

Policy Holder Name ______________________DOB __________Relationship: ____________________

Referring MD ______________________**Office Contact**____________________**Phone #**____________

GENETIC LABS (NIPT, AFP, CARRIER SCREENING) DRAWN BY OB: ☐ YES ☐NO ***If yes, send results**

URGENT REQUEST: **Please call 972-566-5600 opt 1, once a referral is sent for urgent requests**

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

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

☐ Twin-to-twin transfusion syndrome
☐ Bladder Outlet Obstruction
☐ Hydrops
☐ Spina Bifida
☐ Congenital Diaphragmatic Hernia
☐ Lung Mass (CPAM)
☐ **Other:** ____
☐ **Amino/FISH completed: DATE:** ________________________
☐ **MRI completed: DATE/Location:**________________________

FETAL ECHOCARDIOGRAM:

☐ Singleton ☐ Multiples
Indication:____

Desired Location (Please mark):

☐ **MEDICAL CITY DALLAS:** 7777 FOREST LANE, SUITE D-1190, DALLAS, TX 75230
☐ **MCKINNEY BAYLOR SCOTT AND WHITE:** 5236 W. UNIVERSITY DR, PROFESSIONAL BLDG 1, SUITE 3700, MCKINNEY, 75071
☐ **MCKINNEY:** 1700 N. LAKE FOREST DRIVE, MCKINNEY, TX 75230
☐ **PARIS**: 2850 LEWIS LANE, SUITE 101, PARIS, TX 75460
☐ **WICHTIA FALLS:** 2629 PLAZA PARKWAY, SUITE A3, WICHITA FALLS, TX 76038
☐ **SHERMAN:** 1313 N. Travis Street, Suite 104, Sherman, TX 75092 **(as of 10/1/21)**