OBSTETRIX OF SAN JOSE | pediatrix

MATERNAL-FETAL MEDICINE REFERRAL FORM

Is this referral URGENT? ◯ **Yes** ◯ **No** **Date of Request:** _____

PROVIDER & PATIENT INFORMATION

Requesting Provider: _____ Phone #: _____

Patient Name: _____ Date of Birth: _____

Patient Phone #: _____ Alternate #: _____

Interpreter Needed? ◯ Yes ◯ No *Please attach patient demographic sheet.*

CLINICAL INFORMATION

Please Indicate: ◯ Singleton ◯ Twins ◯ Other _____

EDC: _____ EDC Based On: ◯ LMP _____ ◯ US at ____ wk ____ d on _____ (date) ◯ IVF

Gravida: _____ Para: _____ SAB: _____ TAB: _____ Current Weight: _____

INDICATIONS

◯ Abnormal Screening Results
◯ Advanced Maternal Age
◯ Bleeding
◯ Diabetes, Pre-existing *(Type I or Type II)*
◯ Diabetes, Gestational
◯ History of Stillbirth
◯ History of Preterm Birth
◯ Late Prenatal Care
◯ Obesity
◯ Oligohydramnios
◯ Placenta Previa
◯ Polyhydramnios
◯ Preterm Labor
◯ Repetitive Miscarriage
◯ Size / Dates Discrepancy
◯ Suspected / Known Fetal Anomaly
◯ Other _____

ULTRASOUNDS*

◯ 1st Trimester / Viability
◯ NT NIPT ☐ Yes ☐ No
◯ Anatomy Ultrasound *(18-20 weeks)*
◯ NT & Detailed NIPT ☐ Yes ☐ No
◯ Fetal Echocardiogram
◯ Growth
◯ Amniocentesis *(includes Genetic Counseling)*
◯ CVS *(Includes Genetic Counseling)*
◯ NST or BPP
◯ Fluid Check
◯ Gyn Pelvic US (non obstetric)
◯ Other _____

CONSULTS / TRANSFER OF CARE / DIABETES & NUTRITION SERVICES

*To prevent any delay in scheduling, please attach **all relavent records and labs**.*

◯ MFM Consult ☐ Preconception
◯ MFM Consult with US if indicated
◯ Transfer of Care Request Reason: _____
◯ Other _____
◯ Genetic Counseling
◯ Diabetes and Pregnancy Program (DAPP)
◯ Nutrition ☐ Preconception

Practice policy is to perform a Detailed/Anatomy Ultrasound in the 2nd and 3rd trimester for any patient we have not previously seen in current pregnancy. We also perform a transvaginal cervical length screen at 18 – 24 weeks.* ***Referring Provider authorizes MFM consultation if abnormal findings, unless: explain here* _____

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