

Referral Appointment Request

Please fax your referral to 954-447-2708 or call 954-447-2704.

PREFERRED LOCATION (if applicable)

☐ Hollywood Office
Hollywood, FL 33021

REFERRING PROVIDER

Referring Physician and Clinic: _____

Phone: _____ Fax: _____

PATIENT INFORMATION

Patient First Name: _____ MI: _____ Last Name: _____

DOB: _____

Cell Phone: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Does your patient require an interpreter? ☐ YES ☐ NO If YES, language spoken: _____

INSURANCE INFORMATION Please provide a copy of insurance card.

Insurer: _____ ID #: _____ Group #: _____

Policy Holder: _____ DOB: _____ Relationship to Patient (if applicable): _____

REQUIRED INFORMATION

LMP: _____ EDD: _____ G: _____ P: _____ Blood type: _____ Antibody screen: _____

NIPT: ☐ Normal ☐ Abnormal ☐ Not done

BMI: _____

IVF: ☐ Yes ☐ No

☐ Singleton ☐ Twins ☐ Other: _____

LEVEL OF PARTICIPATION:

☐ Consultation with subsequent outpatient visits/ultrasounds (co-management)

☐ Transfer of care

☐ Other: _____

INDICATIONS:

- ☐ Abnormal NIPT
- ☐ Advanced maternal age
- ☐ Bleeding
- ☐ Diabetes, gestational
- ☐ Diabetes, pre-existing (Type I or Type II)
- ☐ History of IUFD or stillbirth
- ☐ Hypertension: chronic or gestational (please circle one)
- ☐ IVF
- ☐ Known/suspected fetal anomaly
- ☐ Known/suspected placental abnormality
- ☐ Known/suspected polyhydramnios/oligohyramnios
- ☐ Maternal medical complication: _____

- ☐ Medication exposure
- ☐ Multifetal gestation
- ☐ Obesity, BMI: _____
- ☐ Other genetic condition: _____
- ☐ Preterm labor
- ☐ Recurrent pregnancy loss
- ☐ Seizure disorder
- ☐ Size/date discrepancy
- ☐ Viability
- ☐ Other: _____

ULTRASOUNDS/PROCEDURES: Consultation will be included if indicated by ultrasound findings.

- ☐ First trimester screening
- ☐ Detailed first trimester ultrasound
- ☐ Detailed second trimester ultrasound
- ☐ Screen for malformations, anatomy scan
- ☐ Growth ultrasound
- ☐ Biophysical profile (BPP)
- ☐ Amniocentesis
- ☐ CVS
- ☐ NST

CONSULTATIONS/COUNSELING:

- ☐ MFM consult with ultrasound, if indicated
- ☐ Diabetes and pregnancy
- ☐ Genetic counseling

Please complete fully and include OB Flowsheet, labs and other related records with the referral.