FAX

pediatrix | CARDIOLOGY OF THE ROCKY MOUNTAINS

Fetal Echocardiogram Referral Form

Please fax referral to 303-839-5844 or email to DenverCardi@pediatrix.com.
Please include clinic notes, labs, and other related records with the referral.

PREFERRED LOCATION (if applicable)

☐ **Presbyterian St. Luke's Office**
2055 High Street, Suite 255
Denver, CO 80205
Phone: 303-860-9933

☐ **Scottsbluff Clinic**
North Medical Plaza
2 West 42nd Street, Suite 1300
Scottsbluff, NE 69361
Phone: 303-860-9933

☐ **Sky Ridge Office**
10099 Ridge Gate Parkway,
Suite 300
Lone Tree, CO 80124
Phone: 303-860-9933

☐ **Fort Collins Clinic**
126 Harvard Street, Suite 1
Fort Collins, CO 80525
Phone: 303-860-9933

☐ **Glenwood Springs Office**
1830 Blake Ave., Suite 208
Glenwood Springs, CO 81601
Phone: 303-860-9933

REFERRING PROVIDER

Referring Physician or Clinic: _____ Date: _____

Phone: _____ Fax: _____ Contact: _____

PATIENT INFORMATION

Patient Name (First Middle Last): _____ Sex: ☐ Male ☐ Female

DOB (mm-dd-yy) _____ Patient Email (optional) _____ Phone: _____

INSURANCE INFORMATION

Insurer: _____ Plan Name and Number: _____

REQUESTED SERVICES

☐ Fetal echocardiogram and consultation

G: _____ P: _____

EDC: _____

Delivering Hospital: _____

Genetic testing completed (if applicable):

☐ First Trimester Screen: _____

☐ NIPT: _____

☐ CVS: _____

☐ Amniocentesis: _____

INDICATION FOR REFERRAL

Maternal Indications

☐ Diabetes

☐ Family History of CHD

☐ IVF pregnancy

Fetal Indications

☐ Abnormal NIPT or Genetic testing:
_____

☐ Extracardiac anomalies:
_____

☐ Fetal arrhythmia:
_____

☐ Suspected complex CHD:
_____

Additional Comments (if applicable): _____

_____

_____

Physician Signature: _____ Order Date: _____

Appointment Date and Time: _____

Thank you for the opportunity and privilege to care for your patient.