

Please fax your referral to 214-345-2369

Dallas Office - M. Perot Building

8160 Walnut Hill Ln
Suite 320
Dallas, TX 75231

Allen Office - Twin Creeks Building II

1111 Raintree Circle
Suite 290
Allen, TX 75013

Richardson Office

2821 E President George Bush Hwy
Suite 304
Richardson, TX 75082

Rockwall Office

6701 Heritage Pkwy
Suite 145
Rockwall, TX 75087

PATIENT INFORMATION

Patient: _____ DOB: _____ SSN: _____

Address: _____ City: _____ ZIP: _____

Phone: _____ Alt Phone: _____ Email: _____

INSURANCE INFORMATION

Insurance: _____ ID #: _____ Group #: _____

Policy Holder: _____ DOB: _____ Relationship to Pt. _____

Referring Provider: _____ NPI# _____

Phone: _____ FAX: _____ Contact: _____

REQUIRED INFORMATION

Level of Participation:

- One time visit for consultation & management plan
- Consultation with subsequent outpatient visits (co-management)
- Transfer of care

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

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

PATIENT SPECIAL NEEDS:

- Ambulation constraint
- Hearing impaired
- Physical/mental challenges
- VAD (cardiac assisted device)
- None
- Other: _____

1st TRIMESTER SCREENING: Includes pre-test counseling, NT US and lab work. If abnormal, genetic counseling, detailed ultrasound and additional testing will be offered. If screening is normal, do you want patient to return for detailed ultrasound at 18-20 weeks? YES NO

GENETIC COUNSELING: Includes detailed family history, US (if indicated), and management plan.

- NO Aneuploidy screening
- NO Carrier screening
- ABNORMAL NIPT, QUAD, 1st TM screen Please fax ALL results
- ABNORMAL carrier screening Please fax ALL results
- Advanced maternal age
- Family history: _____
- Previous pregnancy/child with: _____
- Teratogen exposure: _____
- Preconception
- Other: _____

1st TRIMESTER ULTRASOUND: Consultation and management plan provided, if indicated by US findings

- Bleeding
- Size/Date discrepancy
- Suspected ectopic
- Other: _____

2nd/3rd TRIMESTER ULTRASOUND: Consultation and management plan provided, if indicated by US findings

- Screen for malformations, Anatomy scan
- Size/Date discrepancy
- Bleeding
- Fibroids
- Multiple gestation, # of fetuses: _____
- Known/Suspected fetal abnormality: _____
- Known/Suspected placental abnormality
- Known/Suspected polyhydramnios or oligohydramnios
- Known/Suspected cervical abnormality
- Biophysical profile (BPP)
- NST
- Other: _____

PERICONSULT: Includes detailed patient history, US (if indicated), and management plan.

- Preconception
- Diabetes, Pre-gestational; Type: _____
- GDM Please fax GTT results
- Hypertension; Chronic or gestational (please circle one)
- Isoimmunization
- Multiple gestation, # of fetuses: _____
- Thyroid dysfunction
- Hx of IUFD or stillbirth
- Recurrent pregnancy loss
- Anticardiolipin antibody/LAC positive
- Seizure disorder
- Obesity, BMI: _____
- Maternal medical complication: _____
- Other: _____

FETAL ECHO:

- Known/Suspected fetal arrhythmia
- Family history of cardiac condition
- IVF
- Other: _____

Please fax all ultrasound reports, prenatal labs, maternal screening, and copy of insurance card with this request.