MATERNAL-FETAL MEDICINE OF GREATER NASHVILLE | obstetrix Part of Pediatrix Medical Group

Referral Appointment Request

Please fax your referral to: 615-760-5486

PREFERRED LOCATION (if applicable)

☐ **Nashville Clinic** 615-760-5231
☐ **Summit Clinic** 615-886-9730
☐ **Hendersonville Clinic** 615-822-7759

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:

❒ One time visit for consultation and management plan
❒ Consultation with subsequent outpatient visits (co-management)
❒ Ultrasound only (with consultation for abnormal findings)

INDICATIONS:

❒ Abnormal NIPT, QUAD, 1st TM screen (please fax all results)
❒ Advanced maternal age
❒ Anticardiolipin antibody/LAC positive
❒ Bleeding
❒ Diabetes, gestational
❒ Diabetes, pre-existing (Type I or Type II)
❒ Fibroids
❒ History of IUFD or stillbirth
❒ Hypertension: chronic or gestational (please circle one)
❒ Isoimmunization
❒ Known/suspected fetal anomaly
❒ Known/suspected placental abnormality
❒ Known/suspected polyhydramnios/olighyramnios
❒ Known/suspected cervical abnormality
❒ Maternal medical complication: _____
❒ Multifetal gestation, # of fetuses: _____
❒ Obesity, BMI: _____
❒ Pelvic pain
❒ Recurrent pregnancy loss
❒ Seizure disorder
❒ Size/date discrepancy
❒ Suspected ectopic
❒ Teratogen exposure: _____
❒ Viability

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

❒ First trimester screening
❒ Detailed first trimester anatomy ultrasound
❒ Detailed second trimester ultrasound
❒ Screen for malformations, anatomy scan
❒ Growth ultrasound
❒ Biophysical profile (BPP)
❒ Fetal echocardiogram
❒ Amniocentesis
❒ Gyn pelvic US (non-obstetric)
❒ NST

CONSULTATIONS/COUNSELING:

❒ MFM consult with ultrasound, if indicated
❒ Preconception
❒ Diabetes, pre-gestational; Type: _____
❒ GDM (please faxt GTT results)
❒ Genetic counseling
❒ NO aneuploidy screening
❒ NO carrier screening
❒ Family history: _____
❒ Previous pregnancy/child with: _____

Please include clinic notes, labs and other related records with the referral.
Please call to schedule your referral and then fax your completed form to our office.

Visit our website for more information on locations and clinicians. pediatrix.com/MFMGreaterNashville