OBSTETRIX
MATERNAL-FETAL MEDICINE
SPECIALISTS OF HOUSTON

pediatrix

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Circle preferred physician if desired

Please fax or email your referral to 281-419-3040 or referrals_obxhouston@mednax.com

We have partnered with Leading Reach, a HIPAA-secure, web-based referral management platform. Please contact our office for more information or to create a free account to send future referrals.

❒ The Woodlands	❒ Kingwood	❒ Willowbrook	❒ Tanglewood	❒ Katy	❒ Midtown	❒ Sugar Land	❒ One Fannin	❒ Tomball	❒ Northwest	❒ Cypress
9180 Pinecroft Drive Suite 300 The Woodlands, TX 77380 281-419-4600	600 Rockmead Suite 211 Kingwood, TX 77339 346-616-2777	17200 State Hwy. 249 Suite 220 Houston, TX 77064 832-529-4331	5757 Woodway Drive Suite 275 Houston, TX 77057 713-324-0180	23530 Kingsland Blvd Suite 204 Katy, TX 77494 832-913-1702	2100 Travis St. Suite 1250 Houston, TX 77002 346-348-1980	12603 Southwest Frwy Suite 315 Stafford, TX 77477 346-245-5186	7400 Fannin Suite 720 Houston, Texas 77054 832-403-2185	13426 Medical Complex Dr. Suite 200 Tomball, Texas 77375	17070 Red Oak Drive Suite 214 Houston, Texas 77090	13201 Fry Road Suite 130 Cypress, TX 77433

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

PATIENT SPECIAL NEEDS:

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

LMP: _____ EDD: _____ G: _____ P:_____ Blood type: _____ Antibody screen: _____
Does your patient require an interpreter? ❒ YES ❒ NO If YES, language spoken: _____

❒ **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

1st TRIMESTER ULTRASOUND: Consultation and management plan provided, if indicated by US findings
❒ Bleeding
❒ Size/Date discrepancy
❒ Suspected ectopic
❒ Other: _____

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: _____

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.