OBSTETRIX OF COLORADO | pediatrix

Obstetrix Referral Form

Please include clinic notes, labs, and other related records with the referral.

Please fax referral to desired location below.

❒ **Obstetrix at Avista**
80 Health Park Dr.
Suite 235
Louisville, CO 80027
Phone: 303-860-9990
Fax: 303-839-7761

❒ **Obstetrix at Pres/St. Lukes**
2055 High St.
Suite 230
Denver, CO 80205
Phone: 303-860-9990
Fax: 303-839-7761

❒ **Obstetrix at Skyridge**
10103 Ridgegate Parkway
Suite 212
Lone Tree, CO 80124
Phone: 303-792-5585
Fax: 303-792-3788

❒ **Obstetrix at Swedish**
701 E. Hampden Ave.
Suite 530
Englewood, CO 80113
Phone: 303-761-1013
Fax: 303-761-1730

❒ **Rose Medical Center HealthOne**
4500 East 9th Ave.
Suite 210
Denver, CO 80220
Phone: 303-320-2121
Fax: 303-320-7107

❒ **Obstetrix at Glenwood Springs**
1830 Blake Ave.
Suite 208
Glenwood Springs, CO 81601
Phone: 303-860-9990
Fax: 303-839-7761

❒ **Obstetrix at Vail Clinic**
50 Buck Creek Rd.
Suite 100
Avon, CO 81620
Phone: 303-860-9990
Fax: 303-839-7761

❒ **Obstetrix at Durango**
1 Mercado St.
Suite 105
Durango, CO 81301
Phone: 303-860-9990
Fax: 303-839-7761

❒ **Obstetrix at Casper**
6350 E. 2nd St.
Casper, WY 82609
Phone: 303-860-9990
Fax: 303-839-7761

❒ **Obstetrix at Cheyenne**
2301 House Ave.
Suite 400
Cheyenne, WY 82001
Phone: 303-860-9990
Fax: 303-839-7761

❒ **Obstetrix at Greeley**
1801 16th St.
Suite C1-412
Greeley, CO 80634
Phone: 970-810-2007
Fax: 970-744-5296

DATE OF REFERRAL: _____ **DESIRED SCHEDULING TIME FRAME FOR REFERRAL:** _____ **URGENT:** _____

PATIENT INFORMATION

Patient Name: _____ DOB: _____

ZIP: _____ Email: _____

Phone: _____ Alt Phone: _____

REFERRING PROVIDER

Referring Provider: _____ NPI: _____

Phone: _____ FAX: _____

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
❒ 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: _____

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