

# MATERNAL-FETAL MEDICINE REQUEST FOR PATIENT EVALUATION AND CONSULTATION

We appreciate you asking us to participate in your patient's care. Please complete the information below for the patient you wish to have evaluated by UAB Maternal-Fetal Medicine physicians.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Patient's email address: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_ Alternate Phone #: \_\_\_\_\_

Emergency contact/phone #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Name of insured: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Pre-certification/referral #: \_\_\_\_\_

If pregnant, LMP: \_\_\_\_\_ Date of 1st U/S: \_\_\_\_\_ GA at 1st Scan: \_\_\_\_\_

Date of last U/S: \_\_\_\_\_ GA at last scan: \_\_\_\_\_ Best EDC: \_\_\_\_\_

Singleton  Twins  Triplets Maternal weight: \_\_\_\_\_ Blood type/Rh: \_\_\_\_\_

Serum screen:  Normal  Abnormal  Not done Cell-free DNA:  Normal  Abnormal  Not done

Referring Physician: \_\_\_\_\_ Office Contact: \_\_\_\_\_

Office phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## **MFM SERVICES REQUESTED:** (Check one or more)

### **Fetal/Ultrasound Visit:**

- First trimester aneuploidy screening (Appointment must be at 11w0d to 13w6d)
- Targeted ultrasound
- Genetic counseling and targeted ultrasound
  - Possible:  Amniocentesis  Chorionic villus sampling

### **Maternal/OB Visit:**

- Medical/obstetric consultation (single visit)
- Assumption of total OB care
- Co-management of OB care
- Comprehensive Addiction in Pregnancy Program (Must start prior to 24 weeks, assumption of total care only)

### **Other:**

- Preconception counseling
- Telehealth visit
- Other (Specify): \_\_\_\_\_

**Diagnoses prompting consultation:** \_\_\_\_\_

\_\_\_\_\_

Will your patient require special assistance during her visit? (please specify, i.e. interpreter, wheelchair, etc.)

\_\_\_\_\_

Pertinent medical records such as labs, clinic notes, and ultrasound reports should be included with this referral form. Appointment confirmation will be faxed to your office within 24 hours of receipt of this form and medical records. Please fax appropriate records to **205.934.7994**. If you have any questions ***or need immediate assistance***, please call **205.934.2173**. Thank you.