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 (MFM).

Pertinent medical records such as labs, clinic notes, and ultrasound reports should be included with this referral form. An 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**.

Patient name: _____ DOB: _____

Address: _____

City, state, ZIP: _____

Patient's email address: _____Primary phone #: _____

Social Security #: ____-____-____ Preferred Language: _____ Interpreter needed?: ☐ Yes ☐No

Insurance company: _____ Name of insured: _____

Policy #: _____ Group #: _____

Referring physician: _____ Office contact: _____

Office phone: _____ Fax: _____

Preferred location of scan (patient will be scheduled at first available location if preferred location is not available):

☐ First available ☐ UAB Women and Infants Center / Cooper Green Mercy Health Services

☐ UAB St. Vincent's Birmingham ☐ UAB Medicine Inverness

Gravida: _____ Parity: _____ BMI: _____ Blood type/Rh:_____ Date of last US:_____

Gestational age at last US: _____

EDD: _____ Established by ☐ LMP (date): _____ ☐ US (date of 1st scan)_____ ☐ IVF (transfer date) _____

☐ Singleton ☐ Twins ☐ Triplets Chronicity (if known) _____

Maternal aneuploidy screen: ☐ Cell-free DNA: ☐ Other (i.e. quad): _____☐ Normal ☐ Abnormal ☐ Not done

Reason(s) for Referral:

1) Diagnosis: _____ ☐ General pregnancy management guidance
Specific question: _____

2) Diagnosis: _____ ☐ General pregnancy management guidance
Specific question: _____

Indications and Diagnoses (check all that apply):

Fetal Diagnosis Clinic: Fetal concerns/suspected fetal anomaly

☐ Abnormal anatomy (describe) _____ ☐ Abnormal genetic screening (describe)_____

☐ Diagnostic testing, e.g. CVS (11-13w) or amnio (15+w)

☐ Complication in multiple gestation _____ ☐ Fetal growth restriction _____%___

☐ Abnormal dopplers ☐ Oligohydramnios ☐ Polyhydramnios

☐ Genetic counseling: indication (ex. child w/ anomaly and/or family history)_____

☐ Other fetal concerns (ex. arrhythmia): _____

MFM Clinic: maternal indication/diagnosis

☐ Chronic hypertension ☐ Obesity ☐ Pre-gestational diabetes ☐ Gestational diabetes

☐ Autoimmune disorder ☐ Thrombophilia ☐ Other (ex. thyroid, cardiac, renal) _____

☐ Poor obstetric history (preterm/stillbirth) ☐ Medication exposure ☐ Substance use

☐ Other (ex. normal multiples): _____

Services Requested (check all that apply):

☐ Consultation (single visit, one time only) ☐ Assumption/transfer of total OB care

☐ Co-management of OB care ☐ Preconception counseling

☐ Comprehensive Addiction in Pregnancy Program (must start prior to 32 weeks, assumption of total care only)

Please note: Referrals and requested services are reviewed and scheduled based on the patient's diagnosis, clinical indications, and established practice guidelines. Also, certain ultrasound exams and services may only be performed within specific gestational age timeframes and clinical criteria. Services requested on referral forms, including STAT requests, do not guarantee scheduling outside of these guidelines.

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