

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 UAB St. Vincent's Birmingham UAB One 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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