Valley Children's HEALTHCARE

PRINT CLEAR FORM

PHYSICIAN ORDER

Maternal Fetal Center/Prenatal Diagnostic Center
Referral Office (559) 353-6700 Fax (559) 353-6710

DEMOGRAPHICS **ESTABLISHED PATIENT IN THE MATERNAL FETAL CENTER: YES ◯ NO ◯**

Name (Last / First / MI): _____ Maiden Name: _____ DOB: _____

Address: _____ ZIP: _____

Phone: _____ Interpreter Needed? Yes ◯ No ◯ Language: _____

CLINICAL INFORMATION: Please submit the following information to assist our practice in providing a quality consultation

• **Prenatal Records** •**Prenatal labs** •**OB ultrasounds** •**AFP/NIPT results** •**Medical records pertinent to medical condition**

Dating by: LMP: _____ or by US on _____ at _____ wks. _____days EDD: _____

Indications/Diagnosis for referral:

☐ **AMA** (Advanced Maternal Age, 35 years and older/genetic consultation is recommended) ☐ **Bleeding** ☐ **Diabetes** ☐ **Hypertension**

☐ **Positive AFP Screen (AFP #):** _____ **(Ultrasound and genetic consultation will be provided)**
☐ **Fetal Anomaly Risk:** _____
☐ **Medical Condition:** _____
☐ **Other:** _____

Perinatal Services ****Fetal ultrasound will be performed as part of a consultation**

☐ Consultation and co-management
☐ Follow up visit and co-management with new diagnosis
☐ Pre-pregnancy consultation
☐ Consultation

Ultrasounds ****By signing this form you are requesting a consultation if a fetal abnormality or maternal risk factor is identified**

☐ First trimester less than 14 weeks
☐ Early anatomy less than or = 15 weeks
☐ Dating (any gestational age)
☐ Other: _____
☐ Nuchal translucency evaluation @ 11-13 weeks
☐ Detailed anatomy @ 18-22 weeks
☐ Fetal echocardiogram @ 22 weeks or greater

Genetic Services/Procedures ****Genetic Consultation will be provided prior to amniocentesis or CVS**

☐ Genetic consultation ☐ Amniocentesis ☐ CVS

Indication: _____

REFERRING PROVIDER: Referral cannot be accepted without a provider's signature as it is a physician's order

Referring physician (Print): _____ (Signature): _____

Date: _____ Contact Person: _____ Phone: _____

Office address/zip: _____ Fax: _____

☐ **AUTHORIZATION REQUESTED** ☐ **AUTHORIZATION APPROVED** (Please fax copy)

PLEASE FAX COPY OF INSURANCE TO ENSURE COVERAGE