Valley Children's HOSPITAL

Maternal Fetal Center / Prenatal Diagnostic Center
Physician Referral Form
Fax: (559) 353-6710
Email: MFCReferral@ChildrensCentralCal.org

PATIENT INFORMATION

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

Address: _____ Zip: _____

Phone: (Daytime Contact #): _____ Other # _____

INSURANCE INFORMATION

☐ **FAX - Copy of Insurance Card** (Front / Back)

Insurance (Name and ID#) _____ Authorization # _____

ADDITIONAL INFORMATION

☐ **FAX - Copy of Labs, Prior Ultrasound Reports, H&P and Progress Notes**

Dating: by LMP _____ or US on _____ at _____ w _____ d

REASON(S) FOR REFERRAL (Check all that apply)

☐ Medical Condition: _____

☐ Fetal Anomaly Risk: _____

☐ AMA (35 or >)

☐ Positive AFP Screen (AFP#) _____

☐ Other _____

SERVICES (Check all that apply)

Screening:
- ☐ Detailed OB Ultrasound (US) ☐ Twins ☐ Triplets
- ☐ Nuchal Translucency (NT) Ultrasound (blood drawn 1 week prior by OB)
- ☐ First Trimester Screen w/ blood draw, NT US, Genetic Counseling
- ☐ Second Trimester Screen w/ blood draw, OB US, Genetic Counseling
- ☐ Other _____

Diagnostic Testing:
- ☐ Amniocentesis
- ☐ Chorionic Villus Sampling (CVS)
- ☐ Other _____

Note: Fetal Echocardiogram is scheduled through Cardiology

Consultation:
- ☐ Perinatology Consult w/ US
  - ☐ Request patient to be co-managed by Perinatologist
- ☐ Perinatology Limited Office Visit w/ US
- ☐ Perinatology Pre-pregnancy Consult
- ☐ Genetic Counseling
- ☐ Other _____

REFERRING PHYSICIAN (Print): _____ (Signature) _____

Today's Date: _____ Contact Person: _____ Phone: _____

Address / Zip: _____ Fax: _____