Service Request/Referral Order

Please circle preferred location.
Robbinsdale  Maple Grove
Phone: 763-581-5140

Today's date ___________________________ Clinic contact person ________________________________

Referring Provider Name ________________________________ * Referring provider phone and fax are required for a copy of any MFM reports

*Referring Provider Phone number: __________________________

*Referring Provider Fax number: __________________________

Patient name _______________________________ DOB _______________ SSN __________________

Best phone number to reach patient __________________________/

Interpreter needed? □ Yes □ No If yes, language ________________________________

LMP _____________________ EDC _____________________ by ultrasound? □ Yes □ No

Indication for Referral/Diagnosis ________________________________

□ Singleton  □ Twins  □ Triplets  □ Quadruplets

Providers please check all that apply.

CONSULTATION: Maternal Fetal Medicine specialist (the patient may proceed with recommendations for further testing or genetic counseling as directed by MFM)

□ one time only  □ co-management  □ transfer of complete OB Care (must be approved by MFM MD)

□ Genetic Counseling (patient may proceed with recommendations for further testing/screening as directed by GC of MFM)

OR

□ Genetic Counseling only

ULTRASOUND: Patients will receive interpretation and consultation of ultrasound findings.

□ First trimester screen US with lab and genetic counseling

□ First trimester complete US (less than 14 weeks gestation) (dating, zygosity, etc.)

□ Limited US (fetal heart rate, position, placental location, AFI)

□ Limited including transvaginal (TVS for cervical length assessment)

□ Comprehensive (level 2) ultrasound (18 weeks gestation & up) (fetal & maternal evaluation includes biometry & anatomy evaluation). AMA patients with no previous screening will be scheduled for genetic counseling.

□ Fetal echocardiogram

□ Follow up comprehensive (growth)

PROCEDURE:

□ Chorionic Villus Sampling (10+0 to 12+6 weeks gestation, genetic counseling will be scheduled)

□ Genetic Amniocentesis (15+ weeks gestation, genetic counseling will be scheduled)

□ Lung maturity amniocentesis (if fetal lungs are mature, delivery will be recommended within 36 hours of results – please schedule accordingly)

FETAL SURVEILLANCE:

□ Biophysical profile w/o NST □ 1x only □ Weekly □ Twice weekly □ Per MFM

□ Biophysical profile with NST □ 1x only □ Weekly □ Twice weekly □ Per MFM

□ Non-stress test (NST) □ 1x only □ Weekly □ Twice weekly □ Per MFM

Physician/CNM/NP Signature: ________________________________

(Reminder: a signed order request, provider fax and phone numbers, and prenatal records are required prior to our office calling the patient.)

Our staff are available to discuss your concerns by phone or assist your staff with the referral process.

Please call us at 763-581-5140

Please fax this form with complete documentation to 763-581-5141.

When we receive all of the following information, your patient will be called to set up an appointment.

□ Prenatal referral form  □ All ultrasound reports from current pregnancy

□ Prenatal reports and labs with blood type □ First trimester screen result or Triple/Quad screen results

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