Maternal Fetal Referral Form

❒ CU Perinatal Center at Children's Hospital – North | f: 720-777-7960

❒ John C. Hobbins Perinatal Center | f: 303-468-3481

Referring provider - ❒ Urgent Appointment Needed

Clinic name _____

Phone number _____

Fax number_____

Physician signature _____

Patient information

Name _____DOB_____ Age_____

Address_____

Phone number 1: _____ Phone number 2: _____

Insurance information (please fill in completely) _____ Self Pay? Y/N

Company Name _____

I.D. # _____Group #: _____

❒ Interpreter needed Language: _____

If required, prior authorization is the responsibility of the referring provider. Thank you.

Maternal history

Has patient been seen by an MFM specialist previously? Y/N If Yes, what provider and where? _____

LMP _____ EDC_____ (by US or LMP) IUI or IVF_____

G _____ P_____ Term_____ Preterm_____ SAB_____ TAB _____ Ectopic_____

Stillbirth_____ Living Child _____

Allergies _____ Blood Type _____ Rh_____ BMI _____

Antibody Screen _____

MFM Service Requested (please check all that apply)

Reason for Consultation Request / Diagnosis ICD-10: _____

Ultrasound (please check all that apply)

- ☐ Early screening for Down syndrome, Sequential or cfDNA
- ☐ Low risk anatomy ultrasound
- ☐ High risk anatomy/genetic ultrasound
- ☐ Doppler Evaluation
- ☐ Fetal Echocardiogram
- ☐ Cervical Length

Diagnostic testing (please check all that apply)

- ☐ Chorionic Villus Sampling (CVS)*
- ☐ Amniocentesis*

Consultation only (please check all that apply)

- ☐ Preconceptual consultation regarding: _____
- ☐ Genetic Counselor Visit

Indication(s) (please check all that apply)

- ☐ Multiple Gestation
- ☐ Gestational Diabetes (A1GDM, A2GDM, Type I Diabetes, or Type II Diabetes)
- ☐ Hypertension
- ☐ Advanced Maternal Age (AMA)
- ☐ In Vitro Fertilization (IVF)
- ☐ Fetal anomaly: _____
- ☐ Other: _____

Please include all indications and patient records with referral

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