Maternal Fetal Referral Form – SOM Locations

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

❒ Littleton Perinatal Center | f: 303-468-3481

❒ Parker Perinatal Center | f: 303-840-4713

❒ Rocky Mountain Perinatology | f: 303-468-3481

Reason for Consultation Request / Diagnosis: _____

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 _____

Genetic Testing (NIPT, AFP/quad) _____

Did patient decline genetic testing? Y/N

MFM Service Requested (please check all that apply)

Ultrasound and Consultation (please check all that apply)

- ☐ 1st Trimester Ultrasound (11-13.6wks)
- ☐ Low risk anatomy ultrasound (20wk, Healthy, no medical concerns, not AMA, BMI less than 30, singleton)
- ☐ High risk anatomy/genetic ultrasound
- ☐ Fetal Echocardiogram (after Genetic ultrasound with MFM)
- ☐ Cervical Length

Diagnostic testing (please check all that apply)

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

Consultation (please check all that apply)

- ☐ Preconceptual consultation regarding: _____
- ☐ Genetic Counselor Visit (MFM follow up as appropriate)

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 such as genetic testing (i.e. NIPT, AFP/quad) and dating ultrasounds with referral.

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Littleton Perinatal Center | 7720 S Broadway, Suite 190, Littleton, CO 80122 | p: 303-315-6100 | f: 303-468-3481
Parker Perinatal Center | 9397 Crown Crest Blvd., Suite 310, Parker, CO 80138 | p: 303-315-6100 | f: 303-840-4713
Rocky Mountain Perinatology | 1107 S Lemay Ave, Suite 410, Fort Collins, CO | p: 303-315-6100 | f: 303-468-3481