Maternal Fetal Medicine
1850 Hickory St., Ste 200A, Abilene, TX 79601
325-692-0626 phone 325-692-0638 fax

Referral Request

Patient name: _____ **Referring physician**: _____
Address: _____ Apt. #:_____
City: _____ State: _____ ZIP: _____
SS #: _____ DOB: _____ Home phone #:_____
Primary language: _____ Cell phone #:_____
Insurance: _____ Policy holder: _____ DOB: _____
Insurance #: _____ ID #: _____ Group #:_____
2nd Ins:_____ Insured: _____ DOB: _____ ID/Group:_____

Referring physician phone #:_____ Fax #: _____

***** PLEASE FAX A COPY OF THE PATIENT'S INSURANCE CARD(S) *****
***** IF A REFERRAL IS NECESSARY, PLEASE OBTAIN PRIOR TO SCHEDULING *****

LMP: _____ EDC: _____ Blood type: _____ G: _____

Services requested (check all that apply)	**Indications**
☐Consultation	☐Abnormal quad/triple screen
☐Anatomy U/S with consult	☐Advanced maternal age Fasting_____
☐Anatomy U/S	☐Choroid plexus cyst 2hr_____
☐Size & date/growth check with consult	☐Diabetes (**specify if gestational**)
☐Size & date/growth check	☐Fibroids, uterine
☐Non-stress testing	☐History of birth defects/genetic disease (specify)
☐Biophysical profile	_____
☐Genetic counseling	☐Hyperthyroidism/hypothyroidism
☐Genetic amniocentesis	☐IUGR
☐1st trimester/sequential screening	☐Late prenatal care
☐Fetal echocardiography	☐Medication exposure (list below)
☐Version	_____ _____
☐Other services, please specify:	_____ _____
_____	☐Multiple gestation (specify) _____
_____	☐Poor OB history
Additional notes/requests:	☐Post dates
_____	☐Size/date discrepancy (specify) _____
_____	☐Suspected/known fetal abnormality (specify)
_____	_____
_____	☐Other indications
_____	_____
_____	_____

PLEASE INCLUDE PRENATAL LABS AND MOST RECENT OFFICE NOTE WHEN INDICATED
To be completed by Maternal Fetal Medicine staff and faxed back to referring physician's office for confirmation

Date/time of appointment: _____ Appointment made by: _____