Valley Children's HEALTHCARE

PHYSICIAN ORDER

Maternal Fetal Center/Prenatal Diagnostic Center Referral
Office (559) 353-6700 Fax (559) 353-6710

DEMOGRAPHICS **ESTABLISHED PATIENT IN THE MATERNAL FETAL CENTER: YES / NO**

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

Address: _____ ZIP: _____

Phone: _____ Interpreter Needed? Yes / No Language: _____

CLINICAL INFORMATION: Please submit the following information to assist our practice in providing a quality consultation

• **Prenatal Records** •**Prenatal labs** •**OB ultrasounds** •**AFP/NIPT results** •**Medical records pertinent to medical condition**

Dating by: LMP: _____ or by US on _____ at _____ wks _____days EDD: _____

Indications/Diagnosis for referral:

- ☐ **AMA (Advanced Maternal Age, 35 years and older/genetic consultation is recommended)** ☐ **Bleeding** ☐ **Diabetes** ☐ **Hypertension**
- ☐ **Positive AFP Screen (AFP #): _____ (Ultrasound and genetic consultation will be provided)**
- ☐ **Fetal Anomaly Risk: _____**
- ☐ **Medical Condition: _____**
- ☐ **Other**: _____

Perinatal Services **Fetal ultrasound will be performed as part of a consultation

- ☐ Consultation and co-management
- ☐ Follow up visit and co-management with new diagnosis
- ☐ Pre-pregnancy consultation
- ☐ Consultation

Ultrasounds **Consultation and follow up ultrasound will be scheduled as indicated

- ☐ First trimester less than 14 weeks
- ☐ Early anatomy less than or = 15 weeks
- ☐ Dating (any gestational age)
- ☐ Other: _____
- ☐ Nuchal translucency evaluation @ 11-13 weeks
- ☐ Detailed anatomy @ 18-22 weeks
- ☐ Fetal echocardiogram @ 22 weeks or greater

Genetic Services/Procedures **Genetic Consultation will be provided prior to amniocentesis or CVS

- ☐ Genetic consultation
  - ☐ Amniocentesis ☐ CVS

Indication: _____

REFERRING PROVIDER: Referral cannot be accepted without a provider's signature as it is a physician's order

Referring physician (Print): _____ (Signature): _____

Date: _____ Contact Person: _____ Phone: _____

Office address/zip: _____ Fax: _____

PLEASE FAX COPY OF INSURANCE TO ENSURE COVERAGE

☐ **AUTHORIZATION REQUESTED** ☐ **AUTHORIZATION APPROVED** (Please fax copy)