Maternal Fetal Center / Prenatal Diagnostic Center, Sacramento
Physician Referral Order
Office (916) 758-6670 Fax (916) 758-6671

DEMOGRAPHIC

Name (Last / First / MI):_______________ Maiden Name:_______________ DOB:__________

Address: ______________________________ZIP: ______________

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

CLINICAL INFORMATION

Important! Please include the following records from the patient's current pregnancy. Review of these records allows us to provide the most accurate interpretation of the ultrasound and provide medical advice most appropriate for the patient's pregnancy issues.

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

EDD: ______________ LMP: ______________ US on __________ at___weeks ____days

Indication / Diagnosis: ○ **Fetal Screening** ○**Fetal Anomaly** ○ **Pre Existing Diabetes**
○ **Gestational DM** ○ **Pre Existing Hypertension** ○ **IUGR** ○ **Multiple Gestation**
○ **Prior Poor OB Outcome(Prior preterm or stillbirth)** ○ **Medical Hx of _______** ○ **Bleeding**
Other : ______________________________

○ **CONSULTATION AND CO-MANAGMENT AS NEEDED**

Fetal Ultrasound/other Diagnostic Services: (MFM will discuss US findings):

Ultrasound:

○First Trimester<14wks (76801) ○ NT Screening@ 11-13 weeks (76813) ○ Limited Exam eg AFI/ Fetal Position (76815)

○Low risk Anatomy @20wks (76805) ○ **Detailed** Anatomy @20wks (76811) ○ Cervical Length (76817)

○ Fetal Growth (76816) ○ Fetal biophysical profile (76819) ○ Doppler: Umbilical artery(76820)

○ Doppler: Middle cerebral artery(76821) ○Fetal Echocardiogram @22 weeks (76825)

Additional Services:

☐ *CVS @11-13wks (76945): (***Need blood type/RH, Antibody screen, GC, Chlamydia)*** ***Genetics will be provided prior to visit***

☐ *Amniocentesis @16+wks (59000): (***Need blood type/RH, Antibody screen)***

☐ NIPT (81507 or 81420)

Provider Visit / Consultation

☐ **Genetic Counseling (99243 or 96040)** ☐ **Physician Consultation (99244)** ☐ **Preconception Consult:**

Indication: ______________________________

☐ **Co-Management**

REFERRING PROVIDER

Date: / / Referring Provider (Print): ______________ **Signature**:______________

Contact Person: ______________ Address / Zip: ______________________________

Fax: ______________ Phone:______________

FAX – COPY of INSURANCE TO ENSURE COVERAGE

Insurance Info: ______________________________ Auth # ______________