**Referral Appointment Request**
Please send your referral to Fax: 469-619-2261
<u>If STAT, please also call our office or contact one of our providers directly.</u>

MATERNAL-FETAL MEDICINE OF TEXAS

411 N. Washington Ave., Suite 6400
Dallas, TX 75246
Phone number 214-884-2632

**REFERRING PROVIDER**
Referring provider: ______________________________________________
Contact:___________________________ Phone number: (_____) ______-_______ Fax number: (_____) ______-_______

**PATIENT INFORMATION**
Patient name: ____________________________________________ DOB: __________________________________
Phone number: (_____) ______-_______ Address: ________________________________________________
Insurance: ________________________________ Policy Number: ________________________________
Policy Holder: _____________________________ Group Number: _______________________________

LMP: ______________ EDD: ______________ Blood type: ________ HIV: ______ RPR: ________ Hep B: _______
Genetic screening (circle one): Low risk Abnormal Declined

<u>Please fax this request with a copy of the insurance card, prenatal records and lab results.</u>

**MFM SERVICE INVOLVEMENT (required – please complete involvement, ultrasound type and indication)**

☐ <u>One-time</u> visit for consultation and management plan (UNLESS additional MFM follow-up is indicated)
☐ Consultation with follow-up ultrasounds at our MFM office (routine growth ultrasounds, antenatal testing, etc)

**1ST TRIMESTER ULTRASOUND**
☐ NT scan
☐ CVS (10w0d-13w6d)

**2ND / 3RD TRIMESTER ULTRASOUND**
☐ Detailed anatomy ultrasound (18-20 weeks)
☐ Fetal echocardiogram* (22-24 weeks)
Indication: ☐ IVF ☐ Family history ☐ Fetal arrhythmia
*Detailed anatomy will also be performed with fetal echocardiogram
☐ Amniocentesis

**MATERNAL INDICATIONS:**
☐ Advanced maternal age
☐ Hypertension (circle one): CHTN GHTN
☐ Diabetes (circle one): T1DM T2DM GDM
<u>Would you like our office to manage your patient's diabetes?</u> YES NO
☐ IVF pregnancy
☐ Obesity: Pre-pregnancy BMI ___________
☐ History of IUFD
☐ Thyroid dysfunction
☐ Other: ________________________________

☐ **GENETIC COUNSELING**
Indication: ________________________________________

☐ **PRECONCEPTION COUNSELING**
Indication: ________________________________________

**FETAL INDICATIONS:**
☐ Screening for malformation (routine anatomy scan)
☐ Size/Date discrepancy
☐ Multiple gestation, # of fetuses: ________________
☐ Suspected fetal anomaly: ______________________
☐ Suspected placental abnormality: _______________
☐ Suspected polyhydramnios/oligohydramnios
☐ Abnormal genetic screening
☐ Other: ________________________________________

NOTE: Unless otherwise noted, appointment timing will be at the discretion of our providers. <u>If STAT, please also call our office or contact one of our providers directly.</u>