Maternal-Fetal Medicine Referral

16400 NW 2nd Avenue, Suite 101, Miami, FL 33169
For appointments, call 786-416-6990 or fax 786-975-1658.

OBSTETRIX Medical Group

Requesting Provider: _____ Phone No:_____ Date of Request:_____

Patient Name: _____Date of Birth: _____

Patient Phone Number:_____ Alternate Number:_____

Insurance Name: _____Auth No._____HMO ___ PPO ___ EPO ___ POS ___

Interpreter Needed: Y / N Indicate preferred language:_____

CLINICAL INFORMATION:

Please Indicate: □ Singleton □ Twins □ Other _____

EDC: _____ EDC Based on: □ LMP_____ □ US at _____wk _____d on _____(date)

Gravida:_____ Para:_____ SAB:_____ TAB:_____ Current Weight::_____ IVF: Y / N_____

INDICATIONS:

□ Abnormal Screening Results
□ Abnormal Analytes_____
□ Advanced Maternal Age
□ Cervical Insufficiency
□ Diabetes, Pre-existing (Type I or II)
□ Diabetes, Gestational
□ Growth
□ History of Stillbirth
□ Hypertension
□ Fetal Growth Restriction
□ Late Prenatal Care
□ Multiples _____
□ Obesity
□ Oligohydramnios
□ Placenta Previa
□ Polyhydramnios
□ Preterm Labor
□ Recurrent Pregnancy Loss
□ Screening for Malformation
□ Size/Dates Discrepancy
□ Suspected / Known Fetal Anomaly
□ Vaginal Bleeding
□ Other_____
_____

ULTRASOUNDS: (Allow 1-1 1/2 hours for US and procedures) PROCEDURES/TESTS:

Our policy is to perform Detailed Ultrasound in 2nd & 3rd trimester for any patient we have not seen previously in current pregnancy
Our policy is to perform a transvaginal cervical length screen at 18-24 wks
Referring provider authorizes MD consultation if abnormal US findings unless explained here_____

□ NT with 1st tri US if indicated
□ NT with 1st tri US and Detailed US at 18-20 weeks
Please indicate: 1st tri blood drawn Y / N Form no._____
□ Detailed US at _____weeks
□ Fetal echo
□ BPP
□ Amniocentesis (includes genetic counseling)
□ CVS (includes genetic counseling)
□ Fetal Lung Maturity Amnio with NST
□ NST □ AFI _____
□ TVUS
□ Other _____

PLEASE FAX PRENATAL LABS / SCREENING RESULTS FOR THIS PREGNANCY TO INCLUDE:
Blood Type/Rh CA Prenatal Screening Results Other Non-invasive Testing Results

CONSULTS (Allow 1 hour for consultation) Prenatal records/labs required prior to scheduling

□ MD Consultation (□ pre-conception)
□ MD Consult with US if indicated
□ Other_____
□ Genetic Counseling
□ Telehealth Consultation

Fax margin – We cannot read anything written in this space