PHOENIX CHILDREN'S Medical Group

Fetal Care Referral/Order

Name: _____
MR #: _____
DOB: _____
or Apply Patient Label

Phone: (602) 933-4411
Fax: (602) 933-4268

Today's Date: _____

****PLEASE ATTACH*****

☐ **PATIENT DEMOGRAPHICS** ☐ **US REPORTS** ☐ **RELEVENT RECORDS** ☐ **FETAL GENETIC STUDIES**

Patient Name:		**DOB:**
Patient Phone:	**Mobile:**	**Alt. or Emergency number:**
Referring Physician:	**Phone:**	**Fax:**
Practice Contact:	**Phone:**	
EDC:		
Suspected Fetal Diagnosis/ICD-10 Code(s):		
Additional Information:		

Referral Request		
Select one:	☐ **Stat**	☐ **Routine**

Fetal Diagnostics	
☐	Fetal MRI and US Follow-up -Single Gestation (74712, 76816):
☐	Fetal MRI and US Follow-up -Multiple Gestation (74713,76816): **X** _____
☐	MRI Pelvis (Suspected Placenta concerns only-72195)
☐	US Follow-up (76816):
☐	Transvaginal US (Suspected Placenta Accreta only-76817):

Fetal Cardiology	
☐	Fetal Echo and Cardiology Consult (76825,76827,93325)

Consultations					
☐	Cardiothoracic Surgery	☐	Neurology	☐	Plastic Surgery
☐	Genetics	☐	Neurosurgery	☐	Psychology
☐	Hematology/Oncology	☐	Orthopedics	☐	Urology
☐	Neonatology	☐	Palliative Care	☐	Other (please specify)
☐	Nephrology	☐	Pediatric Surgery	☐	Other (please specify)

Physician Signature: _____ **Date:** _____ **Time:** _____

Physician Printed Name: _____

REFERRING PHYSICIAN INSTRUCTIONS

- **If an urgent appointment is needed, please contact the clinic scheduler at 602-933-4411.**
- Non-urgent appointments: fax referral form, records, authorization/referral to 602-933-4268.
- Once received, patient will be contacted to schedule an appointment within 24 hours if all records are received.