



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 RELEVANT 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: | <input type="checkbox"/> Stat | | <input type="checkbox"/> Routine |
| Fetal Diagnostics | | | |
| <input type="checkbox"/> Fetal MRI and US Follow-up -Single Gestation (74712, 76816): | | | |
| <input type="checkbox"/> Fetal MRI and US Follow-up -Multiple Gestation (74713,76816): # fetuses _____ | | | |
| <input type="checkbox"/> MRI Pelvis, US Follow-up and Transvaginal US ***Suspected Placenta concerns only-(72195, 76816, 76817) | | | |
| Specialty consult per MRI impression, as appropriate: (please specify below) | | | |
| <input type="checkbox"/> Cardiothoracic Surgery | <input type="checkbox"/> Neurology | <input type="checkbox"/> Plastic Surgery | |
| <input type="checkbox"/> Genetics | <input type="checkbox"/> Neurosurgery | <input type="checkbox"/> Psychology | |
| <input type="checkbox"/> Hematology/Oncology | <input type="checkbox"/> Orthopedics | <input type="checkbox"/> Urology | |
| <input type="checkbox"/> Neonatology | <input type="checkbox"/> Palliative Care | <input type="checkbox"/> Other (please specify) | |
| <input type="checkbox"/> Nephrology | <input type="checkbox"/> Pediatric Surgery | | |
| Fetal Cardiology | | | |
| <input type="checkbox"/> Fetal Echo and Cardiology Consult (76825,76827,93325) | | | |
| Specialty Consultation Only order(s) | | | |
| <input type="checkbox"/> Cardiothoracic Surgery | <input type="checkbox"/> Neurology | <input type="checkbox"/> Plastic Surgery | |
| <input type="checkbox"/> Genetics | <input type="checkbox"/> Neurosurgery | <input type="checkbox"/> Psychology | |
| <input type="checkbox"/> Hematology/Oncology | <input type="checkbox"/> Orthopedics | <input type="checkbox"/> Urology | |
| <input type="checkbox"/> Neonatology | <input type="checkbox"/> Palliative Care | <input type="checkbox"/> Other (please specify) | |
| <input type="checkbox"/> Nephrology | <input type="checkbox"/> Pediatric Surgery | <input type="checkbox"/> 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 option 3**
- Non-urgent appointments: fax referral form, records, authorization/referral to 602-933-4268.
- Once received, patient will be contacted to schedule an appointment within 1 business day if all records are received.

