PMC Maternal Fetal Medicine Referral Form

PMC MATERNAL FETAL MEDICINE
Affiliated with **PMC Physician Network**

A COMMUNITY BUILT ON CARE

Patient Name: _____ Date of Birth: ____/____/____ Referral Date: ____/____/____

Address: _____

Home Phone: _____ Cell Phone: _____

Do you provide consent for our office to leave a message? Yes or No (circle one)

Insurance Company: _____ Group ID#: _____

Partner's Name: _____ Partner's Phone Number: _____ Relationship to Patient: _____

Can the office discuss medical information with this person? Yes or No (circle one)

Pre-certification? Yes or No (circle one) Authorization #: _____

Social Security: _____ Medical Record Number: _____

Referring Physician: _____

Referring Practice Name: _____ ☐ MFM ☐ OBGYN

Referring Physician Address: _____

Referring Physician Direct Phone Line for MD use/follow-up: _____

Referring Physician Office Phone Number: _____ Fax Number: _____

Pregnancy dating – EDC: _____ by ☐ LMP ☐ Ultrasound Date: ____/____/____ ☐ Conception /REI GA: _____

Problem or concern to be addressed:

- ☐ AMA
- ☐ Fetal anomaly suspected or concerned, at risk
- ☐ Genetic marker screening
- ☐ Genetic condition or predisposition, family history
- ☐ Dating, growth issue
- ☐ Multifetal pregnancy: _____ (# of fetuses)
- ☐ Twin-Twin Transfusion Syndrome
- ☐ Medication Exposure
- ☐ Maternal medical condition

_____

- ☐ Prior poor OB outcome

_____

- ☐ If we find an unexpected issue with the mother, the fetus(es), **or the pregnancy in general**, would you like a consultation at the time of the visit?

  Yes or No (circle one)
- ☐ Other

_____

_____

_____

Antibody screen and blood type (MUST be DOCUMENTED on ALL patients): _____

Interpreter Needed: Yes or No (circle one) Language: _____