Children's Hospital Central California

Amazing People. Incredible Care.

Maternal Fetal Center / Prenatal Diagnostic Center

Physician Referral Form

Fax: (559) 353-6710

Email: MFCReferral@ChildrensCentralCal.org

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Red Boxes Denote REQUIRED Fields

PATIENT INFORMATION

Name (Last / First / MI): DOB: / /

Address: Zip:

Phone: (Daytime Contact #): Other #

INSURANCE INFORMATION

FAX - Copy of Insurance Card (Front / Back)

Insurance (Name and ID#) Authorization #

ADDITIONAL INFORMATION

FAX - Copy of Labs, Prior Ultrasound Reports, H&P and Progress Notes

Dating: by LMP / / or US on at w d

REASON(S) FOR REFERRAL (Check all that apply)

- ☐ Medical Condition:
- ☐ Fetal Anomaly Risk:
- ☐ AMA (35 or >)
- ☐ Positive AFP Screen (AFP#)
- ☐ Other

SERVICES (Check all that apply)

Screening:
- ☐ Detailed OB Ultrasound (US) ☐ Twins ☐ Triplets
- ☐ Nuchal Translucency (NT) Ultrasound (blood drawn 1 week prior by OB)
- ☐ First Trimester Screen w/ blood draw, NT US, Genetic Counseling
- ☐ Second Trimester Screen w/ blood draw, OB US, Genetic Counseling
- ☐ Other

Diagnostic Testing:
- ☐ Amniocentesis
- ☐ Chorionic Villus Sampling (CVS)
- ☐ Other

Note: Fetal Echocardiogram is scheduled through Cardiology

Consultation:
- ☐ Perinatology Consult w/ US
  - ☐ Request patient to be co-managed by Perinatologist
- ☐ Perinatology Limited Office Visit w/ US
- ☐ Perinatology Pre-pregnancy Consult
- ☐ Genetic Counseling
- ☐ Other

REFERRING PHYSICIAN Name:

Today's Date: Contact Person: Phone:

Address / Zip: Fax: