Southwest Perinatal Associates

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Consultation Request to Maternal Fetal Medicine

TODAY'S DATE ________ /________ / ________

PATIENT INFORMATION

PATIENT NAME ______________________________ DATE OF BIRTH ________ /________ / ________
LAST FIRST MI

ADDRESS ______________________________
STREET OR BOX CITY STATE ZIP

PHONE (H) ______________ (C) ______________ (W) ______________

REFERRING PROVIDER ______________________________

ADDRESS ______________________________
CITY STATE ZIP

PHONE ______________ FAX ______________ NURSE/CONTACT ______________

EMPLOYER ______________ HOW DID YOU HEAR ABOUT US ______________

SPOUSE'S NAME ______________________________
LAST FIRST MI

INSURANCE INFORMATION

(INCLUDE COPY OF YOUR INSURANCE CARD)

PRIMARY INSURE: ❑ SELF ❑ OTHER

GROUP # ______________ ID # ______________

AUTHORIZATION ______________________________

PREGNANCY INFORMATION

LMP ______________ EDD ______________ G ________ P ________

CURRENT PREGNANCY: ❑ SINGLETON ❑ MULTIPLE

INDICATION/DIAGNOSIS

❑ ULTRASOUND SCREEN FOR ABNORMALITIES ❑ CONSULTATION IF INDICATED

❑ MULTIPLE GESTATION

❑ SIZE-DATE DISCREPANCY

❑ DIABETES ❑ AMA ❑ HTN ❑ OBESITY

❑ POSITIVE MARKERS SCREEN (1ST OR 2ND TRIMESTER)

❑ FAMILY HX OF ______________________________

OTHER ______________________________

PREFERRED DOCUMENTATION

- SERUM SCREEN / MSAFP / NIPT
- ALL PRENATAL LAB WORK / BLOOD TYPE
- ALL ULTRASOUND REPORTS FLOW SHEETS HISTORY OF OB VISITS
- GESTATIONAL DIABETES / T1DM / T2DM
- 75G RESULTS / 3 HR RESULTS
- MEDICATION LOG
- DOCUMENTATION OF SUGAR LOG
- Hgb A1C If pt Is T1DM/T2DM
- AMA / ABNORMAL SERUM SCREEN / CHOROID PLEXUS CYST / FETAL HEART ABNORMALITY

PLEASE FAX REFERRAL TO : 575-522-4182

PHYSICIAN SIGNATURE ______________________________