REFERRAL FORM Maternal Fetal Medicine St. Vincent's Medical Center
FOR INITIAL APPOINTMENT: FAX to Judy 203-337-3860 (Telephone 203-576-6201)
FOR FOLLOW-UP APPOINTMENTS PROVIDER PLEASE FAX FORM TO Judy, 203-337-3860

NOTE: This form must be completed with each new diagnosis/indication

Patient Name________________________________Date of Birth______________________
Contact Phone #______________________________Appt date/time ____________________

Insurance Co____________________________Insured/pt ID:________________________
Subscriber name if not patient: ___________________Relationship:__________________
Social Security number of insured:_______________Group Number___________________
Precertification needed? (circle) YES NO
Precertification #:____________________Spoke to:_________________Date:___________
# of prior ultrasounds_________ (If 3 or more, precertification REQUIRED)

OB History: ☐ first pregnancy ☐ previous pregnancy with no complications
☐ previous pregnancy with complications (explain): ______________________________
Gravida_______Para_______EDC__________ by LMP:__________ or U/S IVF

Services requested (please check all that apply) ☐ Ultrasound (consultation, if applicable)
☐ Consultation (ultrasound, if applicable) ☐ NST/BPP
☐ **Amniocentesis (≥ 16 weeks)** * ☐ **Fetal echocardiography** *
☐ **1st trimester screening (11 -13weeks 6days) including ultrasound, serum testing & consultation 76801, 76813, 36415, 99242,Gene Care codes 84163, 84702, 80500. Must precert for all)** *
☐ Cervical length ☐ Genetic counseling
☐ Diabetic Teaching ☐ **CALM screening***
☐ Specific requests: ____
(* PRECERTIFICATION REQUIRED)

Clinical indication (please check primary indication): ☐ **Screening exam**

☐ Anomaly, suspected	☐ Fibroid	☐ Recurrent sab
☐ Advanced maternal age	☐ Genetic disease in family	☐ Seizure disorder
☐ Abnormal screening test	☐ Hypertension	☐ Size/date discrepancy
☐ Bleeding <22 weeks	☐ Oligohydramnios	☐ SLE
☐ Bleeding >22 weeks	☐ Postdates	☐ Teratogen exposure
☐ Cervical surgery/incompetence	☐ Polyhydramnios	☐ Thyroid disease
☐ Diabetes, gestational	☐ Preeclampsia	☐ Twins/triplets
☐ Diabetes, pre-gestational	☐ Previa	☐ Viral disease
	☐ Previous Pregnancy complications	

☐ Other: ____

Referring provider's name________________________________UPIN______________

Referring provider's signature____