

Request for Maternal Fetal Medicine Services
 Community Locations
 Fax all referrals to **832-824-7333**

Date: _____

 Check here for ASAP referral

By referring to Maternal Fetal Medicine you will allow us to provide a clinically appropriate evaluation as deemed necessary by our team. Clinically indicated follow up will be provided unless otherwise requested by your office.

* INDICATES A REQUIRED FIELD

 *Please select **ONE** preferred location for your patient's care

<input type="checkbox"/> The Woodlands 936-321-1600	<input type="checkbox"/> Methodist Smith Tower 832-214-0547
<input type="checkbox"/> Northwest Houston 281-517-5040	<input type="checkbox"/> Clear Lake 832-828-1770
<input type="checkbox"/> West Houston 281-646-1480	<input type="checkbox"/> Baytown Telemedicine 281-420-3600
<input type="checkbox"/> Sugar Land 281-491-6830	<input type="checkbox"/> Lufkin Telemedicine 832-828-3904 (**Limited services)

*Patient Information (Please include copy of demographic sheet from your Electronic Medical Record system):

*Patient Name:	*DOB:		
*Address:	*City:	*State:	*Zip:
*Telephone Number:	*Current Pregnancy: <input type="checkbox"/> Not Pregnant <input type="checkbox"/> Singleton <input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> _____		
*Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No Language? _____	*EDD:	*Dating based on: <input type="checkbox"/> U/S <input type="checkbox"/> LMP: _____	G: _____ P: _____

*Referring Provider Information:

*Referring Provider Name:	*Referring Provider NPI #:		
*Office Contact Name:	*Office Contact Telephone #:	*Office Fax:	

*Insurance (Please include copy of insurance card front and back)

*Primary Insured: <input type="checkbox"/> Self <input type="checkbox"/> Other _____ DOB: _____	*Name of Insurance:
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 *Requested Services (Please select all that apply to the patient - must select a minimum of **ONE** requested service)

<input type="checkbox"/> First Trimester Screen (11-13 6/7 weeks)	<input type="checkbox"/> MFM Consult ** _____
<input type="checkbox"/> Ultrasound <14 weeks ** <input type="checkbox"/> Initial Ultrasound <input type="checkbox"/> Multiple Gestation <input type="checkbox"/> Suboptimal Imaging <input type="checkbox"/> Uterine Anomaly <input type="checkbox"/> Other: _____	<input type="checkbox"/> MFM Preconception Consult ** _____ <input type="checkbox"/> Genetic Counseling _____ <input type="checkbox"/> Diabetic Education and Monitoring _____ <input type="checkbox"/> Diabetic Education Only (does not include blood sugar monitoring) _____ <input type="checkbox"/> Nutrition Consult _____ <input type="checkbox"/> Other _____
<input type="checkbox"/> Amniocentesis (>16 wks) (not offered at telemedicine locations)	<i>services will be scheduled as clinically appropriate</i>
<input type="checkbox"/> Anatomy **	** Services offered at Lufkin
<input type="checkbox"/> Cervical Length**	***CVS and Complete Transfer of Care at Pavilion for Women only
<input type="checkbox"/> Growth **	
<input type="checkbox"/> Biophysical Profile**	
<input type="checkbox"/> Antenatal Testing	

 *Indication/Diagnosis (Please select all that apply to the patient - must select a minimum of **ONE** indication/diagnosis)

<input type="checkbox"/> Multiple Gestation <input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> _____	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Routine Ultrasound	<input type="checkbox"/> Nutrition Consult Indication <input type="checkbox"/> Overweight <input type="checkbox"/> Underweight <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Hx of Gastric Bypass <input type="checkbox"/> Other: _____
<input type="checkbox"/> Size-Date Discrepancy	<input type="checkbox"/> Suboptimal Imaging
<input type="checkbox"/> Suspected Fetal Anomaly: _____	<input type="checkbox"/> Positive Screen (include copy of lab)
<input type="checkbox"/> AMA (includes genetic counseling check if declines GC <input type="checkbox"/>)	<input type="checkbox"/> REI/IVF
<input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> Gestational	<input type="checkbox"/> Other Medical History: _____
<input type="checkbox"/> Family History of: _____	
<input type="checkbox"/> Other: _____	

To avoid delays in scheduling, please fax this form to **832-824-7333** along with patient medical records, including prenatal labs for amniocentesis, records pertinent to the reason for referral, labs, previous ultrasound reports, a copy of the patient's ID and front and back of the insurance card.