Texas Children's Fetal Center Referral (North Austin)

Date				
Referring physician name			**Office phone**	**Office fax**
Practice contact/referral coordinator			**Office phone**	**Office fax**
Patient name			**Patient date of birth**	
Patient address (street/city/state/zip)				
Patient phone			**Alternate phone**	
Translator needed? If yes, what language?			**Patient e-mail address**	
Primary insurance carrier	**Phone**	**Policy #**	**Group #**	**Subscriber**
Secondary insurance carrier	**Phone**	**Policy #**	**Group #**	**Subscriber**
Diagnosis/Indication for referral		**Gestational Age**	**LMP**	**EDD**

Services Requested (please check all that apply):

- O Comprehensive fetal evaluation as deemed necessary by Texas Children's Fetal Center
- O Consultation with specific Texas Children's Specialty (indicate selection(s) below):

O Craniofacial/Plastics	O Neurology	O Orthopedics	O Fetal Intervention/Surgery
O Genetics	O Neurosonology	O Pediatric Surgery	O Maternal Fetal Medicine
O Nephrology	O Neurosurgery	O Urology	O Other: _____

O Fetal MRI O Fetal Ultrasound O Fetal Echo w/ Fetal Cardiology Consult O Transfer of Care (pending approval)

Additional Questions

Consultation and imaging reports will be transmitted back to your office as fast as possible. In addition to these written materials, would you also like to receive a phone call from the consulting physician? O Yes, phone number: _____

Is there an additional care provider (i.e. primary OB/GYN) that you would like us to include in post-consult communication?

O Yes, name:_____ Phone: _____ Fax: _____

Please fax this form along with all patient medical records including labs, ultrasounds, and demographic info to 512-640-3094.

Texas Children's Fetal Center
North Austin
737-229-2636
832-822-BABY (2229)
Fax: 512-640-3094

Texas Children's Hospital®
Pavilion for Women