Texas Children's Hospital | Pavilion for Women

REQUEST FOR OBSTETRICAL INFECTIOUS DISEASE SERVICES (including Zika screening/consulting)

Baylor College of Medicine — Department of Obstetrics & Gynecology

A. LOCATION:

Texas Medical Center
Texas Children's Pavilion for Women
6651 Main Street, Suite F320, Houston, TX 77030

Appointments or questions call 832 826 7500, option 1
Fax the referral form to 832 825 9401

Instructions: (1) Complete referral form (2) Fax form and copy of driver's license and insurance card. (3) Scheduling team will call patient to schedule.

B. PATIENT AND REFERRING INFORMATION: *ALL FIELDS ARE REQUIRED*

Patient name: Patient DOB:

Address: City: State: Zip: Email:

Home #: Cell #: Work# :

Emergency contact and phone#: Is an interpreter needed? ☐Yes ☐ No **IF Yes**, what language?

Referring Provider: Address: City: State: ZIP:

Phone #: Fax #: Nurse/Contact:

Insurance Information: Please include a copy of the insurance card
Primary Insured: ☐Self ☐Other DOB:_________________________

Name of Insurance: ______________________ Global Authorization: ______________________

Group#: ______________________________ ID#: ________________________________

Pregnancy information: ☐ Check here if not applicable

LMP: _________________

EDD: _________________ (by ☐US or ☐LMP)

G__________P_________

C. INDICATION / DIAGNOSIS: *Due to CMS Program Memorandum AB-01-144 Change Request 1724, dated September 26, 2001, effective January 1, 2002 REFERRING DIAGNOSIS IS REQUIRED for a diagnostic testing. Suspected or rule-out statements are not applicable, if no confirmed diagnosis, please list symptoms.*

☐ Fetal Anomaly
☐ Travel exposure
☐ Positive testing
☐ Suspected Zika partner exposure

D. REQUIRED DOCUMENTATION: Please include copies of the below for all referrals, as appropriate

- Insurance card
- ALL prenatal labwork and ultrasound reports

E. For Zika referral, complete the following questions:

1. Is the referred patient currently pregnant?
   ☐ Yes, pregnant ☐ No, the patient is not eligible for this clinic.

2. **IF Yes**, has the patient or her partner traveled outside the US during this pregnancy?
   ☐ Yes ☐ No
   → **IF Yes**, who traveled? Patient ☐ Partner ☐ Both☐

3. **IF Yes**, has the patient traveled to Mexico, Caribbean, or Central/South America or other areas currently defined by CDC as Zika exposure risk?
   ☐ Yes ☐ No
   → **IF Yes**, note the location of travel for the
   PATIENT:__________________
   PARTNER (if applicable) ________________

   What date range did the **PATIENT** travel?
   Start ____________ End _____________ ☐ Not applicable

   What date range did your **PARTNER** travel?
   Start ____________ End _____________ ☐ Not applicable

4. Does the **PATIENT** <u>currently</u> have any 2 or more of the following symptoms?
   ☐ Yes
   → **IF Yes**, mark symptoms
   ☐ Fever
   ☐ Maculopapular rash
   ☐ Malaise
   ☐ Arthralgia
   ☐ Conjunctivitis

   ☐ No
   → **IF No**, did the **PATIENT** <u>**previously**</u> have any of the following symptoms **AFTER** her travel?
   ☐ Yes ☐ No
   → **IF Yes**, mark symptoms
   ☐ Fever
   ☐ Maculopapular rash
   ☐ Malaise
   ☐ Arthralgia
   ☐ Conjunctivitis

5. Does the **PATIENT's PARTNER** <u>currently</u> have any 2 or more of the following symptoms?
   ☐ Yes
   → **IF Yes**, mark symptoms
   ☐ Fever
   ☐ Maculopapular rash
   ☐ Malaise
   ☐ Arthralgia
   ☐ Conjunctivitis

   ☐ No
   → **IF No**, did the **PATIENT'S PARTNER** <u>previously</u> have any of the following symptoms **AFTER** his/her travel?
   ☐ Yes ☐ No
   → **IF Yes**, mark symptoms
   ☐ Fever
   ☐ Maculopapular rash
   ☐ Malaise
   ☐ Arthralgia
   ☐ Conjunctivitis