Baylor College of Medicine
DEPARTMENT OF OBSTETRICS & GYNECOLOGY

Texas Children's Hospital®

Request for Maternal Fetal Medicine Services

North Austin Campus
9835 N Lake Creek Parkway, Austin, TX 78717

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.
Please fax completed form and any supporting clinical documentation to ***512-640-3094***

Date: _____ Check here for **ASAP** referral □

Patient Information:			
Patient Name:	**DOB:**		
Address:	**City:**	**State:**	**Zip:**
Telephone Number:	**Current Pregnancy:** □ Singleton □ Twins □ Triplets □ _____		
Interpreter Needed? □ Yes □ No Language?_____	**EDD:**	**Dating based on:** □ U/S □ LMP: _____	
Referring Provider Information:			
Referring Provider:	**Office Contact:**		
Office Contact Telephone #:	**Office Fax:**		
Insurance: *Please include copy of insurance card front and back.*			
Primary Insured: □ Self □ Other _____ DOB: _____	**Name of Insurance:**		
Group #:	**ID #:**		

Requested Services *(check all that apply to the patient)*

□ Ultrasound <14 weeks
□ First Trimester Screen (11-13 6/7 weeks)
□ Cervical Length
□ Amniocentesis (≥ 16 wks) *send prenatal labs with referral
□ Anatomy
□ Growth
□ Antenatal Testing
□ Other _____

□ MFM Consult
□ Preconception Consult
□ Genetic Counseling
□ Diabetic Education and Monitoring
□ Diabetic Education Only *does not include blood sugar monitoring
□ Other Nutrition Consult _____

services will be scheduled as clinically appropriate

Indication/Diagnosis *(check all that apply to the patient)*

□ Initial Ultrasound
□ Routine Ultrasound
□ Suboptimal Imaging
□ Uterine Anomaly
□ Multiple Gestation □ Twins □ Triplets □ _____
□ Size-Date Discrepancy
□ Suspected Fetal Anomaly _____
□ Other _____

□ Diabetes □ Type I □ Type II □ Gestational
□ Hypertension
□ Other Medical History _____
□ AMA *includes genetic counseling check if declines GC □
□ Positive Screen *include copy of lab*
□ Family History of _____
□ REI/IVF
□ Other _____

To avoid delays in scheduling, please fax this form along with patient medical 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.