Baylor College of Medicine

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

Texas Children's Hospital®

Request for Maternal Fetal Medicine Services

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.
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 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 □ 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 □ Nutrition Consult □ Non-invasive Prenatal Testing (NIPT)/ Cell free DNA **services will be scheduled as clinically appropriate**
Indication/Diagnosis *(check all that apply to the patient)*	
□ Positive carrier screen *(include copy of lab)* □ Initial Ultrasound □ Routine Ultrasound	□ Diabetes □ Type I □ Type II □ Gestational □ Hypertension □ History of pre-term delivery

□ Uterine Anomaly □ Multiple Gestation □ Twins □ Triplets □ _____ □ Size-Date Discrepancy □ Suspected Fetal Anomaly □ Suspected Fluid or growth abnormality	□ AMA *includes genetic counseling check if declines GC □ □ Family History of _____ □ REI/IVF □ Other _____