Texas Children's Hospital | Pavilion for Women

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

Baylor College of Medicine — DEPARTMENT OF OBSTETRICS & GYNECOLOGY

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**

- ☐ **The Woodlands** 936-321-1600
- ☐ **Northwest Houston** 281-517-5040
- ☐ **West Houston** 281-646-1480
- ☐ **Sugar Land** 281-491-6830
- ☐ **Methodist Smith Tower** 832-214-0547
- ☐ **Clear Lake** 832-828-1770
- ☐ **Baytown Telemedicine** 281-420-3600
- ☐ **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:** ☐ Not Pregnant ☐ Singleton ☐ Twins ☐ Triplets ☐ _____		
***Interpreter Needed?** ☐ Yes ☐ No Language?_____	***EDD:**	***Dating based on:** ☐ U/S ☐ 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:** ☐ Self ☐ Other _____ DOB: _____	***Name of Insurance:**

***Requested Services** *(Please select all that apply to the patient – must select a **minimum of ONE** requested service)*

- ☐ Ultrasound <14 weeks **
  - ☐ Initial Ultrasound ☐ Multiple Gestation
  - ☐ Suboptimal Imaging ☐ Uterine Anomaly
  - ☐ Other: _____
- ☐ Amniocentesis (≥ 16 wks) (not offered at telemedicine locations)
- ☐ Anatomy **
- ☐ Cervical Length**
- ☐ Growth **
- ☐ Biophysical Profile**
- ☐ Antenatal Testing
- ☐ MFM Consult **_____
- ☐ MFM Preconception Consult **_____
- ☐ Genetic Counseling _____
- ☐ Diabetic Education and Monitoring
- ☐ Diabetic Education Only (does not include blood sugar monitoring)
- ☐ Nutrition Consult _____ _____ _____
- ☐ Other _____ _____

services will be scheduled as clinically appropriate

** **Services offered at Lufkin**

***CVS and Complete Transfer of Care at Pavilion for Women only

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

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

*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.*