Today’s Date:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

□ Norfolk Campus □ Princess Anne Campus □ Peninsula Campus

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**Demographic Information:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 of SSN:

Primary Phone Number: E-mail Address:

Address: City, State, Zip:

**Insurance Information:**

Insurance Name: Phone:

Address: City, State, Zip: \_\_\_\_\_\_

Subscriber’s Name: Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber ID#: Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization # (If required):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pregnancy Dating** **(\*\*Must be completed before patient will be scheduled)**

G/P: \_\_\_\_\_\_\_\_\_\_\_ EDD: \_\_\_\_\_\_\_\_\_\_\_\_\_ LMP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Earliest ultrasound: GA \_\_\_\_\_\_\_\_\_\_\_\_\_ (Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Fetal genetic screening (FTS/NIPT/Quad): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Weight/BMI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Language: □ English □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Translator required: □ yes □ no

**Service Requested**

Indication for referral (Check all that apply.  Please cross out any services that are not desired):

**Ultrasound Only (no anomaly suspected, no consult/discussion with MFM requested)**

|  |  |  |
| --- | --- | --- |
|  | **Indication** | **Patient will be scheduled for:** |
|  | Dating/Viability | Dating/Viability US |
|  | First trimester anatomy evaluation | First trimester anatomy US |
|  | Second trimester anatomy evaluation | Second trimester anatomy US |
|  | Fetal echocardiogram (indication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | Fetal echocardiogram |

**Antenatal Testing Only**

|  |  |  |
| --- | --- | --- |
|  | **Indication** | **Patient will be scheduled for:** |
|  | Non-stress test (frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | NST |
|  | Biophysical profile (frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | BPP |

**Fetal/Placental Concern**

|  |  |  |
| --- | --- | --- |
|  | **Indication** | **Patient will be scheduled for:** |
|  | Suspected fetal anomaly (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | Morphology, Consult US, Genetic consult |
|  | Suspected placental/umbilical anomaly (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | Morphology US, Consult US |
|  | Suspected/Risk for fetal growth restriction | Morphology US, Consult US |
|  | Multiple gestation | Twin US, Consult US |
|  | Medications/Exposure (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | Morphology US, Consult US, Genetic consult |
|  | Multiple gestation | Twin US, Consult US |

**Maternal**

|  |  |  |
| --- | --- | --- |
|  | **Indication** | **Patient will be scheduled for:** |
|  | Gestational diabetes (1hrGTT\_\_\_\_, 3hrGTT\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_) | Gestational diabetes class |
|  | Pre-gestational diabetes (Diet only/insulin; HgbA1C\_\_\_\_\_\_) | NPD, morphology US, Fetal echo |
|  | Maternal medical condition (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | MFM office consult, Morphology US |
|  | History of pregnancy complication (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | Morphology US, Consult US |
|  | Preconception (indication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | Preconception consultation |

**Genetic**

|  |  |  |
| --- | --- | --- |
|  | **Indication** | **Patient will be scheduled for:** |
|  | Abnormal fetal genetic screening | Morphology US, Genetic consult |
|  | Personal/Family history of genetic/congenital disorder (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | Morphology US, Genetic consult |

□ **Desire transfer of care** **to EVMS (delivery at Sentara Norfolk General Hospital)**

Indication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Transfer of care patients may be seen by EVMS High Risk or Low Risk provider depending on the indication

**Time frame request**

□ Urgent (within 7 days) □ Routine (within 4 weeks) □ At a specific gestational age (date range) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional notes (cross out if not applicable):**

□ MFM consultation and/or additional studies when indicated by chart review and/or day of service findings

Referring Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*Please send all applicable medical records for review (including: ultrasound reports, lab results, and office visit notes).

The patient will be contacted with the date and time of their scheduled appointment.

Appointment Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Contacted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_