OhioHealth

PATIENT REFERRAL FORM

OhioHealth Physician Group
Maternal Fetal Medicine

SCHEDULING: (614) 566.4378 **FAX:** (614) 533.1216

URGENT: ☐ Yes ☐ No ***If referral is urgent – please call office and send** Date: ________________

INSTRUCTIONS

Please fax this form along with a copy of your patient's prenatal records (CBC, blood type, any labs pertaining to diagnosis, ultrasound reports, obstetric surgery reports, first trimester screen results, quad screen results, and other genetic screening results) as well as a *copy of their insurance card*.

DEMOGRAPHICS

Patient Name: ______________________________ DOB: _____________ SSN: __________________
Phone: (H): ____________________ (C): __________________ (W): __________________
Address: ____
EDD: _____________ LMP: _____________ Gravida: ____________ Para: ____________

Insurance Company: ____

PLEASE CHOOSE FROM ULTRASOUND, CONSULT AND GENETICS *AND* ASSOCIATED INDICATION

Ultrasound* (w/ genetics - if needed):

*MFM Physician will consult based on findings

- ☐ US OB First Trimester Nuchal Translucency – NT
- ☐ US OB Anatomy
- ☐ US OB Anatomy Detailed/Level II US
- ☐ OB Fetal Growth > 14 weeks
- ☐ Previous Abnormal US
- ☐ Cervical Length
- ☐ Fetal Echo
- ☐ BPP AFI NST
- ☐ Other – Specify: ______________________

Dietitian/Diabetes Education

- ☐ Gestational Diabetes
- ☐ Pre-gestational Diabetes
- ☐ Multiples
- ☐ Hyperemesis
- ☐ Pre/Post Natal Nutrition
- ☐ Other: __________________________

MFM Consult with Ultrasound:

(Imaging required for MFM Consults)

CHOOSE ORDER *AND* INDICATION:

- ☐ Consultation +US OB Anatomy/Detailed Level II
  - ☐ History of Pre-eclampsia
  - ☐ CHTN
  - ☐ Recurrent Pregnancy Loss – 2nd Trimester
  - ☐ Multiple Gestation
    Specify: _________________________
  - ☐ Gestational Diabetes (include 1hr & 3hr results)
  - ☐ Diabetes Mellitus (prior to pregnancy)
  - ☐ Hypertension
  - ☐ Autoimmune Disease
  - ☐ History of Preterm Delivery
  - ☐ Thyroid Dysfunction (include thyroid labs/ thyroid stimulating antibodies)
  - ☐ Thromboembolism/Coagulation Defect
  - ☐ Other: ___________________________

Genetics w/ Ultrasound (if needed):

*MFM Physician will consult based on findings

- ☐ Pre-Pregnancy Counseling
- ☐ Advanced Maternal Age
  Singleton ≥ 35 years
  Multiples ≥ 32 years
- ☐ Abnormal Screening
- ☐ Genetic History (include records)
  Specify: ___________________________
- ☐ Recurrent Pregnancy Loss – 1st Trimester
- ☐ Abnormal Ultrasound
- ☐ Other: ______________________________

Additional Clinic Notes: ____
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REFERRING PROVIDER INFORMATION

Printed Name: ____________________________ Signature: ______________________________

Phone: ______________________ Fax: __________________________

Address: ____

Internal Use Only: **All Records Received Date:** ______________ **Appointment Date:** ________________