MATERNAL-FETAL MEDICINE REQUEST FOR PATIENT EVALUATION AND CONSULTATION

We appreciate you asking us to participate in your patient's care. Please complete the information below for the patient you wish to have evaluated by UAB Maternal-Fetal Medicine physicians.

Patient Name: ______________________________ DOB: ______________
Address: ______________________________
City, State, Zip: ______________________________
Patient's email address: ______________________________
Primary Phone #: ______________ Alternate Phone #: ______________
Emergency contact/phone #: ______________________________
Insurance Company: ______________ Name of insured: ______________
Policy #: __________ Group #: __________ Pre-certification/referral #: ______________
If pregnant, LMP: __________ Date of 1st U/S: __________ GA at 1st Scan: __________
Date of last U/S: __________ GA at last scan: __________ Best EDC: __________
☐ Singleton ☐ Twins ☐ Triplets Maternal weight: __________ Blood type/Rh: __________
Serum screen: ☐ Normal ☐ Abnormal ☐ Not done Cell-free DNA: ☐ Normal ☐ Abnormal ☐ Not done

Referring Physician: ______________________________ Office Contact: ______________
Office Phone: ______________________________ Fax: ______________________________
Specific Physician: ☐ No (first available) ☐ Yes (Dr. ______________)
Preferred Location: ☐ UAB Medicine ☐ Ascension St. Vincent's Birmingham ☐ Grandview

MFM SERVICES REQUESTED: (Check one or more)

Fetal/Ultrasound Visit:

☐ First trimester aneuploidy screening (Appointment must be at 11w0d to 13w6d)
☐ Targeted ultrasound
☐ Genetic counseling and targeted ultrasound
Possible: ☐ Amniocentesis (> 15-16 weeks GA) ☐ Chorionic villus sampling (10-12 weeks GA)

Maternal/OB Visit:

☐ Medical/obstetric consultation (single visit)
☐ Assumption of total OB care
☐ Co-management of OB care
☐ Comprehensive Addiction in Pregnancy Program (Must start prior to 32 weeks, assumption of total care only)

Other:

☐ Preconception counseling
☐ Telehealth visit
☐ Other (Specify): ______________________________

Diagnoses prompting consultation: ______________________________

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Will your patient require special assistance during her visit? (please specify, i.e. interpreter, wheelchair, etc.)

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Pertinent medical records such as labs, clinic notes, and ultrasound reports should be included with this referral form. Appointment confirmation will be faxed to your office within 24 hours of receipt of this form and medical records. Please fax appropriate records to **205.934.7994**. If you have any questions ***or need immediate assistance***, please call **205.934.2173**. Thank you.