

# Order and referral form

504.896.6694



**Fax all lab results and prenatal records with this referral form to**

East Jefferson General Hospital	504.503.5485	West Jefferson Medical Center	504.349.2109
Touro	504.897.7149	University Medical Center	504.702.5734

**Patient information (All fields required. If patient is not in LCMC Health system, attach demographics and insurance card)**

Patient name \_\_\_\_\_ DOB \_\_\_\_\_ Phone # \_\_\_\_\_  
 Interpreter needed? Yes No Language? \_\_\_\_\_

**Referring provider information**

Name \_\_\_\_\_ Office # \_\_\_\_\_ Fax # \_\_\_\_\_  
 Office contact \_\_\_\_\_ Email \_\_\_\_\_

**Pregnancy information**

Current pregnancy Single Multiple LMP \_\_\_\_\_ EDD \_\_\_\_\_ By US or LMP \_\_\_\_\_  
 Blood type/RH/Antibody screen \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Genetic testing done? Yes No

**Fetal indication/Diagnosis**

Ultrasound screen for anomalies \_\_\_\_\_  
 Multiple gestation \_\_\_\_\_  
 Size/Date discrepancy \_\_\_\_\_  
 Suspected fetal anomaly \_\_\_\_\_  
 Abnormal aneuploidy screen \_\_\_\_\_  
 Other \_\_\_\_\_

**Maternal indication/Diagnosis**

Diabetes \_\_\_\_\_  
 AMA \_\_\_\_\_  
 CHTN \_\_\_\_\_  
 Fibroids \_\_\_\_\_  
 Family History of birth defect \_\_\_\_\_  
 Family History (please specify) \_\_\_\_\_  
 Other \_\_\_\_\_

**Ultrasound requested**

Anatomy Growth Dating/Viability  
 First trimester screen/NT (11- 13 6/7 wks)  
 Cell free DNA  
 Cervical length ( 14 w or > )  
 CVS (11- 13 6/7 wks)  
 Amniocentesis (16+ wks)  
 Biophysical profile - BPP & NST (after 32 weeks)  
 Doppler assessment  
 Amniotic fluid assessment

**MFM consult**

Transfer OB care to UMC High Risk Clinic: Indication \_\_\_\_\_  
 Consultation for delivery at Touro: Indication \_\_\_\_\_  
 Diabetic education and monitoring (includes MFM consult)  
 Hypertension education and monitoring (includes MFM consult)  
 Preconception consult: Indication \_\_\_\_\_  
 Genetic counseling: Indication \_\_\_\_\_  
 Other (Specify) \_\_\_\_\_

MD signature \_\_\_\_\_ Date/Time \_\_\_\_\_

**To be completed by MFM Clinic**

Appointment scheduled on \_\_\_\_\_ @ \_\_\_\_\_ MFM MD \_\_\_\_\_