

Referral Form Maternal Fetal Medicine



PLEASE FAX REFERRAL FORM TO 954-447-2708 / 954-322-8984

Date: _____ Contact: _____ Referring OB: _____

Office Phone: _____ Fax: _____

First Name: _____ Last Name: _____ DOB: _____

Address: _____ City: _____ : Zip Code: _____

Cell #: _____ Alt #: _____ Age: _____

SSN: _____ Email: _____

G: _____ P: _____ A: _____ Living: _____ EDC: _____ LMP: _____

Insurance: _____ Phone: _____ Member I.D.: _____

Authorization #: _____ Visits Allowed: _____ Exp. Date: _____

PERINATOLOGY CONSULTATION

- Medical Condition
- Preconception Counseling
- Other _____

DIABETES CO-MANAGEMENT

- Gestational Diabetes
- Pre-gestational Diabetes

HYPERTENSION CO-MANAGEMENT

- Chronic hypertension
- Pre-eclampsia

ULTRASOUND

- 1st trimester screen
- Anatomy survey
- Abnormal serum screen
- Multifetal gestation
- Placenta anomalies
- Amniotic fluid abnormalities
- Morbid obesity
- Fetal Growth
- Other: _____

FETAL TESTING

- Amniocentesis
- Biophysical profile
- NST
- Other: _____

GENETIC COUNSELING

- Advanced Maternal Age
- Positive maternal serum screen
- Fetal anomaly
- Medication exposure
- Previous child with: _____
- Family History of: _____
- Recurrent pregnancy losses
- Other: _____

Other medical condition or additional info: _____

Please include authorization and relevant medical records

Hollywood
1150 N 35th Ave, Suite 550
Hollywood FL 33021

Perinatal Center of Florida - Tax ID 65-0363303