University of Iowa

**Please fax all required documents listed below together to 319-356-7556.**

* This form Insurance card (front and back)
* Medical records (see list below)

If no response within 2 business days, please call 319-356-8892

Maternal Fetal Medicine Care Requested

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| **Patient Name** *(last, first, M.I):*  |
| Maiden name: | DOB: | SSN: |
| If interpreter needed, please list language: |
| Patient address: |
| Patient preferred phone: | Emergency contact: |
| Patient e-mail address: |
| **\*Required\*** Insurance name (plan name): |
| Name of policy holder: |
| Policy/Member ID #: |
| Group #: | Relationship to insured: |
| Referring physician: | Office contact person: |
| Office phone #: | Office fax #: |
| Primary obstetrician, if not referring physician: |

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| --- | --- | --- | --- | --- |
| **Care Requested** | Indication | for | referral | (DX): |
| * Preconception MFM consult
* MFM consult (includes level II US)
* Transfer of care/Delivery at UIHC
 | Genetic Counseling Level II US onlyDiagnostic testing (CVS or Amniocentesis) |

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| **Required Records for Referral \*\*Patient will not be scheduled until all records are received\*\*** |
| * All prenatal labs (ABORH, antibody screen, CBC, etc.)
* All prenatal records and clinic notes
* Operative reports (prior c-section or uterine surgery)
* Genetic screening on patient and reproductive partner, if performed
* Ultrasound reports for current pregnancy
* All records related for referral reason (cardiology records, maternal health conditions, if stillbirth – autopsy report and labs, if neonatal death or neonatal condition – infant hospital records)
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