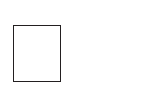
University of Iowa



**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

|  |  |  |  |
| --- | --- | --- | --- |
| **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: | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 only  Diagnostic testing (CVS or Amniocentesis) | | |

|  |
| --- |
| **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) |